SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Filing at a Glance

Company: Continental American Insurance Company

Product Name: MID MED Arkansas	SERFF Tr Num: CAIC-125862108	State: ArkansasLH
TOI: H15G Group Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed	State Tr Num: 40584
Sub-TOI: H15G.002 Large Group Only	Co Tr Num: 28	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Ashley Gibson	Disposition Date: 01/15/2009
	Date Submitted: 10/17/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Mid Med	Status of Filing in Domicile: Pending
Project Number: 28	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association
Filing Status Changed: 01/15/2009	
State Status Changed: 01/15/2009	Deemer Date:
Corresponding Filing Tracking Number: 28	

Filing Description:

Please see attached submission letter.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Ashley Gibson, Compliance Analyst
2801 Devine Street
Columbia, SC 29205

companycompliance@caicworksite.com
(888) 730-2244 [Phone]
(803) 929-4925[FAX]

Filing Company Information

Continental American Insurance Company	CoCode: 71730	State of Domicile: South Carolina
2801 Devine Street	Group Code:	Company Type: LAH
Columbia, SC 29205	Group Name: Continental Amer Ins Co	State ID Number:
(803) 256-6265 ext. [Phone]	FEIN Number: 57-0514130	

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50.00 per policy/package
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	$50.00	10/17/2008	23259632

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
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Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/15/2009	01/15/2009
Approved-Closed	Rosalind Minor	01/15/2009	01/15/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/17/2008	10/17/2008	Ashley Gibson	11/13/2008	11/13/2008
Pending Industry Response	Rosalind Minor	10/17/2008	10/17/2008	Ashley Gibson	10/28/2008	10/28/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Employer Policy	Form	Ashley Gibson	01/15/2009	01/15/2009
Endorsement	Form	Ashley Gibson	01/15/2009	01/15/2009
Resubmission Letter	Supporting Document	Ashley Gibson	01/15/2009	01/15/2009

Filing Notes

Subject	Note Type	Created By	Created	Date Submitted

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

On

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Your response of 10/28/08	Note To Filer	Rosalind Minor	11/17/2008 11/17/2008
Association Groups	Note To Filer	Rosalind Minor	10/28/2008 10/28/2008

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Disposition

Disposition Date: 01/15/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document	John Doe Applications	Approved-Closed	Yes
Supporting Document	Response Letter	Approved-Closed	Yes
Supporting Document	Certification for Bulletin 9-85	Approved-Closed	Yes
Supporting Document	Resubmission Letter	Approved-Closed	Yes
Form	Association Policy	Approved-Closed	Yes
Form *(revised)*	Association Certificate	Approved-Closed	Yes
Form	Association Certificate	Replaced	Yes
Form	Association Member Enrollment Applicaiton	Approved-Closed	Yes
Form *(revised)*	Employer Policy	Approved-Closed	Yes
Form	Employer Policy	Replaced	Yes
Form *(revised)*	Employer Certificate	Approved-Closed	Yes
Form	Employer Certificate	Replaced	Yes
Form	Employer Employee Enrollment Application	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form *(revised)*	Endorsement	Approved-Closed	Yes
Form	Endorsement	Replaced	Yes

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Disposition

Disposition Date: 01/15/2009
Implementation Date:
Status: Approved-Closed
Comment: As discussed in our telephone conversation on this date, this policy/certificate will only be marketed to the employer groups at this time.

In the future, if you wish to market this product to an association group, you have stated that the association questionaaire will be completed and sent to our Department for prior approval before marketing to a particular association group.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document	John Doe Applications	Approved-Closed	Yes
Supporting Document	Response Letter	Approved-Closed	Yes
Supporting Document	Certification for Bulletin 9-85	Approved-Closed	Yes
Supporting Document	Resubmission Letter	Approved-Closed	Yes
Form	Association Policy	Approved-Closed	Yes
Form *(revised)*	Association Certificate	Approved-Closed	Yes
Form	Association Certificate	Replaced	Yes
Form	Association Member Enrollment Applicaiton	Approved-Closed	Yes
Form *(revised)*	Employer Policy	Approved-Closed	Yes
Form	Employer Policy	Replaced	Yes
Form *(revised)*	Employer Certificate	Approved-Closed	Yes
Form	Employer Certificate	Replaced	Yes
Form	Employer Employee Enrollment Application	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form *(revised)*	Endorsement	Approved-Closed	Yes
Form	Endorsement	Replaced	Yes

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/17/2008
Submitted Date	10/17/2008
Respond By Date	

Dear Ashley Gibson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Association Certificate (Form)
- Employer Certificate (Form)

Comment: Under the definition of Dependent and a handicapped dependent, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 2

- Association Certificate (Form)
- Employer Certificate (Form)

Comment: Please provide written certification that benefits payable a PPO and Non-PPO will comply with our Bulletin 9-85 and that there will be no more than a 25% differential in the payment of benefits to a PPO and Non-PPO.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/13/2008
Submitted Date	11/13/2008

Dear Rosalind Minor,

Comments:

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Response 1

Comments: Dear Ms. Minor,

Please see attached response letter and revised forms. Thank you for your help with this filing!

Sincerely,

~Ashley Gibson

Related Objection 1

Applies To:

- Association Certificate (Form)
- Employer Certificate (Form)

Comment:

Under the definition of Dependent and a handicapped dependent, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Related Objection 2

Applies To:

- Association Certificate (Form)
- Employer Certificate (Form)

Comment:

Please provide written certification that benefits payable a PPO and Non-PPO will comply with our Bulletin 9-85 and that there will be no more than a 25% differential in the payment of benefits to a PPO and Non-PPO.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response Letter

Comment:

Satisfied -Name: Certification for Bulletin 9-85

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Association Certificate	CAI1001A AR		Certificate	Revised	CAI1001A AR	50	CAI1001A AR Certificate

						Arkansas.pdf
Previous Version						
Association Certificate	*CAI1001AAR*	*Certificate*	*Initial*		*50*	CAI1001AAR Certificate Arkansas.pdf
Employer Certificate	CAI10001AR	Certificate	Revised	CAI1001AR	50	CAI1001AR Certificate - Arkansas.pdf
Previous Version						
Employer Certificate	*CAI10001AR*	*Certificate*	*Initial*		*50*	CAI1001AR Certificate - Arkansas.pdf

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

No Rate/Rule Schedule items changed.

Sincerely,
Ashley Gibson

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/17/2008
Submitted Date	10/17/2008
Respond By Date	

Dear Ashley Gibson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Association Policy (Form)
- Association Certificate (Form)

Comment: Before you use an association as the policyholder, this is a reminder that the association must be submitted to our Department for review and approval. I am attaching a questionaire that needs to be completed and information submitted on each association group.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Attachment "Discretionary Group.doc" is not a PDF document and cannot be reproduced here.

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/28/2008
Submitted Date	10/28/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Ms. Minor,
I want to double check and make sure I understand that we can get these association forms approved, but we may not use them until your state has approved the actual associations with the checklist? Is this correct?
I am working on the other objection also!
Thank you for your help!
~Ashley

Related Objection 1

Applies To:

- Association Policy (Form)
- Association Certificate (Form)

Comment:
Before you use an association as the policyholder, this is a reminder that the association must be submitted to our Department for review and approval. I am attaching a questionaire that needs to be completed and information submitted on each association group.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Ashley Gibson

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Amendment Letter

Amendment Date:

Submitted Date: 01/15/2009

Comments:

Dear Ms. Minor,

Thank you for reopening this filing for me! Please see attached resubmission letter and the revised policy and endorsement.

Sincerely,

~Ashley Gibson

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CAI1000AR	Policy/Contract/Fraternal Certificate	Employer Policy	Revised		28	CAI1000GRAR	50	CAI1000GRAR Master Policy - Arkansas.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CAI1038AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Endorsement	Revised		28	CAI1038AR	50	CAI1038AR Endorsement AR.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Resubmission Letter

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Comment:

Resubmission Letter - Arkansas 1-15-09.pdf

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Note To Filer

Created By:

Rosalind Minor on 11/17/2008 02:51 PM

Subject:

Your response of 10/28/08

Comments:

Yes, you are correct. We need to review all the information on the association as outlined in the questionnaire, to ascertain as to whether this is a true group association in accordance with our Law.

You cannot marlket the product to the assocaition group as policyholder until we have approved the association.

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Note To Filer

Created By:

Rosalind Minor on 10/28/2008 01:45 PM

Subject:

Association Groups

Comments:

Yes, you are correct. You cannot use the association until we have approved it. I have disapproved association in the past because they were formed for insurance purposes only.

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Form Schedule

Lead Form Number: CAI1000AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CAI1000AAR	Policy/Contract/Fraternal Certificate	Association Policy	Initial		50	CAI1000AAR Master Policy Arkansas.pdf
Approved-Closed	CAI1001AAR	Certificate	Association Certificate	Revised	Replaced Form #: CAI1001AAR Previous Filing #: 40584	50	CAI1001AAR Certificate Arkansas.pdf
Approved-Closed	CAI1011A	Application/Enrollment Form	Association Member Enrollment Applicaiton	Initial		50	CAI1011A Enrollment App 7.9.08-Final.pdf
Approved-Closed	CAI1000AR	Policy/Contract/Fraternal Certificate	Employer Policy	Revised	Replaced Form #: CAI1000GRAR Previous Filing #: 28	50	CAI1000GRAR Master Policy - Arkansas.pdf
Approved-Closed	CAI10001AR	Certificate	Employer Certificate	Revised	Replaced Form #: CAI1001AR Previous Filing #: 40584	50	CAI1001AR Certificate - Arkansas.pdf
Approved-Closed	CAI1011	Application/Enrollment Form	Employer Employee Enrollment Application	Initial		50	CAI1011 Enrollment App 7.9.08-Final.pdf
Approved-Closed	CAI1010	Application/Enrollment Form	Master Application	Initial		50	CAI1010 Master App-Final.pdf
Approved-Closed	CAI1038AR	Policy/Contract/Fraternal	Endorsement	Revised	Replaced Form #: CAI1038AR Previous Filing #: 28	50	CAI1038AR Endorsement AR.pdf

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
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Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Certificate: Amendment, Insert Page, Endorsement or Rider

CONTINENTAL AMERICAN INSURANCE COMPANY
2802 Devine Street, Columbia, SC 29205
800-433-3036

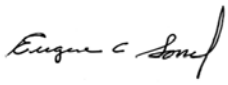
Group Hospital-Medical-Surgical Expense Policy

In return for the payment of premium expressed in the Schedule of Benefits, Continental American Insurance Company, a stock company herein called We, Us, or Our, agrees with the Policyholder to pay the benefits of this Group Policy to the persons insured hereunder, subject to the terms and conditions that follow. This Group Policy is executed as of the Policy Date that is the date of issue. This Group Policy is delivered in, and subject to the laws of the Jurisdiction in which it is issued.

PLEASE READ THIS GROUP POLICY CAREFULLY FOR FULL DETAILS.

This Group Policy is a legal contract and is issued in consideration of the Group Application of the Policyholder, a copy of which is attached, and of the full payment of premiums due. The following pages, including any riders, endorsement, schedule pages, Insured's enrollment forms, applications or amendments, form a part of this Group Policy.

In Witness Whereof, We have caused this Group Policy to be signed by



President

Table of Contents

Non-Participating

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

Schedule of Eligibility

Name of Policyholder: [AC Company]

Address: [123 Any Street, Any City, Any State]

Policy Number: [1234]

Policy Date: [September 1, 2008] All coverage begins and ends at 12:01 AM at the Policyholder's address.

Policy Anniversary: [ ]

Policy Year: The 12 consecutive month period starting on the Policy Date (or the Policy Anniversary) for subsequent Policy Terms.

Jurisdiction: [Any State]

Eligible Classes:

Eligible Participating Entities:

The following individuals are eligible to become insured under this Group Policy:

[Class - Description of Class as defined by the Employer/Policyholder]

Schedule of Premiums

[Member Only	$ 55.17]
[Member Plus One	$ 122.47]
[Member & Family	$ 195.37]

POLICY PROVISIONS

Entire Contract; Changes: This Group Policy, including the endorsements, application, enrollment form, Certificate and the other attached papers, if any, constitutes the entire contract of insurance. No change in this Group Policy shall be valid until approved by Our Executive Officer and unless such approval be endorsed hereon. No agent has authority to change this Group Policy or to waive any of its Provisions.

All statements made by the Policyholder or Insured are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be Used as a defense to a claim unless a copy of the instrument containing the statement is in writing and signed by the Policyholder or the Insured, if applicable, and is or has been furnished to such Policyholder or Insured, if applicable.

Incontestability: After two (2) Years from the Policy Effective Date no statement, except a fraudulent misstatement, will cause the Group Policy to be contested.

Policy Period: The premium due for this Group Policy shall be remitted to Us by an Officer of the Policyholder authorized to remit premiums. The premium bases and rates are as stated in the Schedule of Premiums are due and payable [monthly] on the first day of each [month].

(1) **Change of Premium Rates:** We may, by written notice to the Policyholder at least 31 days in advance, change the rate at which further premiums, including the one then due, shall be computed. The new rate will not be based on this Group Policy's loss experience.

(2) **Grace Period:** A Grace Period of thirty-one days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy will continue in force, subject to Our right to cancel in accordance with Provision entitled "Cancellation". The Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force.

Certificate of Insurance: We shall issue to the Policyholder for delivery to each Insured, an individual Certificate that shall state the essential features of Insurance to which such a person is entitled and to whom benefits are payable when his or her insurance becomes effective.

Data Furnished by the Policyholder: If requested to do so by Us, the Policyholder shall furnish Us with the names of all persons initially insured, of all new persons who become insured, and of all Insureds whose insurance is cancelled, together with the data necessary for the calculation of premium. Failure on the part of the Policyholder to furnish the name of an Insured to Us shall not invalidate his or her insurance; nor shall failure on the part of the Policyholder to report termination of insurance of a person continue such insurance in force beyond the date of termination.

Examination and Audit: We shall be permitted to examine the Policyholder's records relating to the Group Policy at any time during the Policy term and within three Years after expiration of the Policy or until final adjustment and settlement of all claims hereunder, whichever is later.

Cancellation: After the first anniversary, We may cancel this Policy at any time by written notice delivered to the Policyholder or mailed to the last address as shown on Our records. The written notice shall state when, not less than 60 days thereafter, such cancellation shall be effective. After the Policy has been continued beyond its original term, the Policyholder may cancel this Policy or the Participating Entity may cancel its program under this Policy any time by written notice delivered or mailed to Us effective on receipt or on such later dates as may be specified in the notice. Such notice must be provided at least 31 days prior to the cancellation date. In the event of such cancellation by either the Policyholder or Us, We shall promptly return on a pro rata basis the unearned premiums paid, if any, and the Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid. Such cancellation shall be without

prejudice to any claim origination prior to the Effective Date of such cancellation. We may also cancel the insurance available to a Participating Entity subject to the same conditions.

Renewal Subject to Company Consent: The Policy may be renewed for like periods with Our consent, by payment in advance by the Policyholder of the renewal premium determined on the basis of Our premium rate in force for this insurance at the beginning of renewal.

Additional Insureds: Newly eligible persons and their Dependents may be added to the Group, in accordance with the terms of the Policy.

Not in Lieu of Worker's Compensation: This Group Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation insurance.

Assignment: The Group Policy is [non-]assignable. The Insured may [not] assign any of the Policyholder rights, privileges or benefits under the Group Policy [to a PPO network provider of services only].

INCORPORATED PROVISION

The Provisions of the attached Certificate and all amendments to this Group Policy after its Effective Date are incorporated into and made part of this Group Policy.

The Provisions listed below are shown in the Certificate and are hereby incorporated into and made a part of this Group Policy.

Schedule of Benefits
Definitions
Effective Date of Coverage
Conversion
General Provision
Coverage Descriptions
Exclusions and Limitations

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

GROUP HOSPITAL-MEDICAL-SURGICAL EXPENSE INSURANCE CERTIFICATE OF INSURANCE

Continental American Insurance Company, herein referred to as We, Us, or Our, certifies that the person named in the Certificate Schedule, herein referred to as You, is insured for the benefits described in this Certificate. This insurance is subject to the eligibility, any applicable Waiting Period, and Effective Date requirements contained in the Group Policy.

Your insurance is effective at 12:01 a.m. Standard Time at the address of the Group Policyholder on the Certificate Effective Date shown in Your Certificate Schedule.

TEN DAY FREE LOOK

You may cancel the insurance described in this Certificate at any time during the 10 day period after You receive this Certificate. Mail this Certificate with Your written request for cancellation to Our Agent or Us. We will promptly refund the premium paid and the insurance will be void.

IMPORTANT NOTICE

This Certificate is a summary of the Group Policy Provisions that affect Your insurance. It is merely evidence of the insurance provided by such Policy. The Group Policy is a contract between the Group Policyholder and Us. It may be changed or ended without notice or consent of any Insured.

This Certificate replaces any Certificate previously issued by Us to You under the Group Policy.

The benefits described in this Certificate are provided by the Group Policy Number shown on the Schedule and issued to the Group Policyholder whose name is shown on the Schedule.

READ YOUR CERTIFICATE CAREFULLY.

THIS COVERAGE PROVIDES LIMITED BENEFITS UP TO A CALENDAR YEAR MAXIMUM. PLEASE REVIEW YOUR SCHEDULE PAGE FOR BENEFITS.

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

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SECTION

SECTION 1- SCHEDULE OF BENEFITS

Insured - [John A. Doe]
Effective Date - [December 1, 1995]
Initial Premium - [$5.00 Monthly]
Group Policy Holder - [ABC Company]
Group Policy Number - [895]
Certificate Number - [51491]
First Renewal Date - [January 1, 1996]

Plan of Insurance	**In-Network**	**Out-of-Network**
Lifetime Plan Maximum [$5,000 - unlimited] per Insured		
Annual Plan Maximum [$5,000 - unlimited] per Insured		
[Calendar Year] Deductible (Individual/Family)	[$0-$100,000 / $0 - $300,000]	[$0-$100,000 / $0 - $300,000]

[Calendar Year] Deductibles apply to every expense listed below, unless otherwise noted.
Co-payments are not applied to the [Calendar Year] Deductible.
Any paid deductible is used to satisfy both in-network and out-of network requirements

In-Patient Care		
[Surgery-Inpatient, Physicians Services	[Surgery In-patient MD 20% - 100%]	[Surgery In-patient MD 20% - 100%]
[Hospital Inpatient (Facility)	[Hospital In-patient (Facility) 20%-100%]	[Hospital In-patient (Facility) 20%-100%]
[Other Hospital Charges (Including hospital based Professional charges) See Note (A)	[20%-100%]	[20%-100%]
[Physician Services (Inpatient visits)	[20%-100%]	[20%-100%]
[Maternity Care (You and covered Spouse only)	[20%-100%]	[20%-100%]
Out-patient Care -See Note (B)		
[Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	[$0-$150] Co-pay Then [20% - 100%]	[20% - 100%]
[Other Office Services provided during the Office Visit	[20% - 100%] No Calendar Year Deductible	[20% - 100%]
[Urgent Care Facility	[20% - 100%]	[20% - 100%]
[Surgery, Out-patient	[20% - 100%]	[20% - 100%]
[Maternity Care (You and covered Spouse only)	[20% - 100%]	[20% - 100%]
[Supplemental Accidental Benefit	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]]
[Emergency Room (if not admitted in-patient)	[20% - 100%] after [$0-$1000] Co-pay	[20% - 100%] after [$0-$1000] Co-pay]
[Cardiac, Occupational, Physical, Pulmonary & Speech Therapies and Chiropractic See Note (C)	[20% - 100%]	[20% - 100%]
[Transplant-Related Expenses	[0% - 100%	[0% - 100%]
[Routine Physical Exams, Pap Smears, Mammograms; PSA's See Note (D)	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit]	[20% - 100%]] No Calendar Year Deductible [$25-$750] Calendar Year Benefit]]

[Routine Well Child Care	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit	[20% - 100%] No Calendar Deductible] [$25-$750] Calendar Year Benefit]]
Others		
Mental Health	Not covered unless required by law	Not covered unless required by law
Substance Abuse Care	Not covered unless required by law	Not covered unless required by law

NOTES: (A): Other Inpatient Hospital Charges are subject to [$5,000-unlimited] Annual Maximum per Insured.
(B): Outpatient Care is subject to [$5,000-unlimited] Annual Maximum per Insured.
(C): Subject to [5-60] visits per category per [Calendar Year] per Insured.
(D): Routine Physical Exams include all related charges up to [$25-unlimited] Calendar Benefit.

Managed Care Program

Except for maternity admission, a participant or covered dependent is required to call a toll-free number upon learning of a future hospital admission, or to call within two working days after an emergency admission. This toll-free number is on the back of the plan's medical identification card. If this provision is not followed, then hospital charges and all charges related to the hospital admission will be subject to a [$250] per admission penalty, in addition to any deductible that may apply. Maternity admissions **do not** require certification. However, if the newborn baby stays longer in the hospital than the mother, the newborn's continuing hospital stay must be certified. Pre-certification of a hospital stay for medical necessity is not a guarantee of coverage or of payment of benefits. Coverage for benefits will only be determined when the claim is received, eligibility is verified, and it is determined that the benefits were in effect as of the time of service.

A Preferred Provider Organization (PPO) is an organization in which a Group of Hospitals and Physicians have agreed to provide medical care services to Insureds. The PPO for the Policy will be selected by Us. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to Policy Provisions. These benefits are payable at the In-Network benefit level. An Insured has the option to use a PPO Provider or a non-PPO Provider. If an Insured uses a non-PPO, benefits are payable at the Out-of-Network benefit level described above and subject to the out-of network deductible and coinsurance. If a PPO provider is used, auto assignment of benefits would apply unless payment in full is provided at claim submission.

For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the non-PPO level. However, if such treatment is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

Benefits payable under the Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its Providers and be paid directly to the Provider.

Benefits payable under the Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the Providers.

SECTION 2 – DEFINITIONS

Whenever used in the Group Policy:

Accident means: an occurrence which (a) is unforeseen; (b) is not due to or contributed to by a Sickness of any kind; and (c) causes Injury.

Actively-at-work means that on the day that coverage under the plan would begin, a member, or self employed independent contractor, is not absent from work, or if he or she is absent from work, the absence is not related to the health of the member.

[**Allogeneic (Allogenic) Transplant** means: a procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.]

Allowable Charges means: the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

[**Autologous Transplant** means: a procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.]

Complications of pregnancy means: the following:

a) Conditions requiring Hospital Confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; but the term shall **not** include: false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b) Ectopic pregnancy which is terminated.

[**Calendar Year:** A period of one year that starts on January 1 and ends at midnight on December 31st.]

Insured means: a person who is covered for benefits under the Group Policy while it is in effect and those Dependents covered for benefits under the Group Policy.

Deductible/Deductible Amount means: the dollar amount of Eligible Expenses an Insured must pay during each [Calendar Year] before benefits become payable.

Dependent means: Your:

a) married Spouse who lives with You and is under age 65; or
b) unmarried natural child, step child, foster child, adopted child or a child during the pendency of adoption who is not eligible for insurance as an Insured under the Group Policy and who:

    (1) is less than 19 Years old and is Dependent on You; or
    (2) is less than 25 and enrolled in an accredited school as a full-time student at a post-secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to Injury or Sickness. Such child will be covered so long as the coverage of the insured parent or guardian continues in effect and the child remains a Dependent of the parent or guardian.

(3) Becomes incapable of self-support because of mental retardation or physical handicap while insured under the Group Policy and prior to reaching the limiting age for Dependent children. The child must be Dependent on You for support and maintenance. We must receive proof of incapacity. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time after the child attains age [18-21] ; or
(4) Is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent does **not** include:

a) Your grandchild (except where required by law); or
b) A child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b) (2) above.

If a Dependent is eligible to be an Insured, he or she is not eligible as a Dependent.

In the event both parents of a Dependent child are Insureds, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

[Designated Facility means: a facility that We determine to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to You and Your Physician upon request.]

[**Durable Medical Equipment** consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, Hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Physician and be required for therapeutic use.

The following items are **not** considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair gliders, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.]

Elective Treatment means: medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Insured's Effective Date of coverage.

Elective treatment includes, but is not limited to; tubal ligation; vasectomy, breast reduction unless as a result of mastectomy; sexual reassignment surgery; sub mucous resection and /or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; learning disabilities; immunizations; botox injections, treatment of infertility and routine physical examinations.

Eligible Expense as used herein means: a charge for any treatment, service or supply which is performed or given under the direction of a Physician for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Group Policy is in force as to the Insured except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Service means: Health Care Services necessary to screen and stabilize an Insured in connection with an Emergency Medical Condition.

Experimental/Investigational means: a drug, device or medical care or treatment that meets the following:

a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a familiar function, if Federal or state law requires such review and approval;
d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

Geographic area means: the zip code in which the services, procedure, devise, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, devise, drug or supply.

Hospital means: a facility which meets all of these tests:

a) it provides in-patient services for the care and treatment of injured and sick people; and
b) it provides room and board services and nursing services 24 hours a day; and
c) it has established facilities for diagnosis and major surgery; and
d) it is supervised by a Physician; and
e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
f) it is accredited by the Joint Commission of Accreditation of Healthcare Organizations.

Hospital does **not** include a place run mainly: (a) as a convalescent home; or (b) as a nursing home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders or substance abuse or; (d) as a place for the aged unless written authorization is received.

The term Hospital includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Insured; (b) an ambulatory surgical center or ambulatory medical center (c) a mental health Hospital if supervised and licensed by the Department of Mental Health; and (d) a birthing facility certified and Licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital Confinement/Hospital Confined means: a stay of at least 18 consecutive hours or for which a room and board charge is made.

Immediate Family Member(s) means: a person who is related to the Insured in any of the following ways: Spouse, brother-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Injury means: bodily Injury due to an Accident which:

a) results solely, directly and independently of Disease, bodily infirmity or any other causes: and
b) All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

[**Intensive Care Unit** means: a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.]

Medical Necessity/Medically Necessary means: that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will **not** be considered as Medically Necessary if it:

a) is provided only as a convenience to the Insured or Provider; or
b) is not the appropriate treatment for the Insured's diagnosis or symptoms; or
c) exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
d) is Experimental/Investigated or for research purposes; or
e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual Center for Medicare and Medicaid Services Issues Manual; or
h) can be safely provided to the patient on a more cost-effective basis such as outpatient, by different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental or Nervous Disorder(s) means: any condition or Disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder (other than those conditions deemed serious Mental Illness, as defined in the Group Policy) on the date the medical care or treatment is rendered to an Insured.

One Sickness means: a Sickness and all recurrent and related conditions that are sustained by an Insured.

[**Orthopedic Brace and Appliance** means: a supportive device or appliance used to treat a Sickness or Injury.]

Personal Item means: an item that is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

Physician as used herein means:

a) legally qualified person licensed by the state in which he or she practices; and
b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and
c) certified nurse midwives and licensed midwives while acting within the scope of that certification.

The term Physician does **not** include an Insured's Immediate Family Members.

[**[Plan Year]** means: the consecutive 12-month period starting with the Effective Date shown in the Schedule of Benefits. Subsequent [Plan year] run from the anniversary date of Your Effective Date.]

Pre-existing condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the enrollment date. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

Pregnancy shall not be considered a pre-existing condition hereunder

A newborn child, a child placed for adoption, or a newly adopted child under age 18 who begins dependent coverage hereunder within 30 days of birth, placement for adoption, or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

Reasonable and Customary means: the charge, fee or expense which is the smallest of the:

a) actual charge;
b) charge usually made for a covered service by the Provider who furnishes it;
c) negotiated rate, if any;
d) prevailing change made for a covered service in the geographic area by those of similar professional standing as determined by the 90th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies.

Sickness means: a disease or illness including related conditions and recurrent symptoms of the Sickness that begins after the Effective Date of an Insured's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or related cause are considered one Sickness.

Sound Natural Teeth means: natural teeth, the major portion of the individual tooth that is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

Spouse means: Your legal Spouse [or Domestic Partner if recognized by state law.].

Tandem Transplant means: a procedure that requires the patient to undergo two planned autologous stem cell transplants within 6 months. Stem cells are collected once before initial high intensity chemotherapy or radiation therapy. Half of the stem cells are thereafter used for an initial stem cell transplant and the second half are used after recovery from the first procedure.

[Totally Disabled and Total Disability means: with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, it means that the Dependent cannot perform the normal activities of a person of like age and sex.]

[**Urgent Care Facility** means: a licensed facility that provides a variety of medical, surgical and/or pediatric services on an ambulatory emergency or non-emergency basis where the conditions being treated do not require inpatient confinement. Treatment must be under the supervision of a Physician and the facility must include a resident graduate nurse on staff.]

Waiting Period means: The continuous length of time that You must be Actively at Work before becoming eligible to enroll for coverage.

SECTION 3 – EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND ENROLLMENT

You: You are eligible for coverage when You satisfy the Waiting Period, complete a valid [application][enrollment form], and pay the initial premium.
Dependent: A Dependent is eligible for coverage on the later of the date You:

a) become eligible for insurance; or
b) acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the later of the Certificate Effective Date if Your Spouse is Your legal Spouse on that date or the date of the marriage to You.

Natural Child: From moment of birth.

Adopted Child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.

Stepchild: On the date the child begins residing in Your home.

Special Enrollees

You shall be a ***special enrollee*** provided:

- You or your dependant lost other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage, reduction in benefits of the other coverage or you voluntarily terminate the coverage); or,

- Policyholder contributions toward such other coverage were terminated; or,

- You or your dependents were covered under a COBRA continuation provision and the COBRA continuation period has been exhausted.

Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a ***special enrollee***.

An otherwise eligible member who is not covered by the plan, an otherwise eligible member and dependent who are not covered by the plan, or a participant's dependent who is not otherwise covered by the plan may apply for coverage under the plan as a result of the acquisition of a new dependent by the member and shall be a ***special enrollee*** provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent.

A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Coverage for a ***special enrollee***, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall begin as of the first day of the calendar month following a timely enrollment request.

EFFECTIVE DATE

Insured: If You enroll within the Enrollment Period after first becoming eligible to enroll for coverage, Your insurance will take effect on the later of:

a) The date You enroll; or
b) The date You satisfy the Waiting Period, if any,

No coverage will go into effect until You have satisfied the Waiting Period.
Insured Deferred Effective Date: If an eligible person is not Actively at Work on the date his or her insurance under the Group Policy is otherwise to take effect, such insurance will take effect on the day after such person returns to active work.

Dependent, except Dependents Acquired after the Effective Date: The Effective Date of coverage for a Dependent is shown in the Schedule of Benefits. In no event will Dependent coverage become effective prior to the date Your coverage becomes effective.

RENEWABILITY

This Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew the Group Policy because of any change in an Insured's health or physical condition. We may, at Our option, decline to renew the Certificate if We decline to renew the Group.

Unless the Certificate is renewed as stated in this Provision, coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will send written notice of any termination or non-renewal including the reasons for non-renewal or termination of this Certificate by certified mail not less than 60 days prior to the non-renewal or termination, except for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

TERMINATION

An Insured's coverage will terminate at 12:01 a.m. Standard Time at Your home on the earliest of the following:

a) The date the Group Policy terminates or the date a policyholder or sponsoring entity terminates coverage under the Group Policy;
b) The date coverage is terminated by Us for all certificate holders in Your state;
c) The date We receive Your written request to have Your insurance terminated;
d) The end of the period for which premium is paid, subject to the Grace Period;
e) The date an Insured enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces.
f) With respect to a Dependent Spouse, the date the Spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.
g) With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

SECTION 4 - LOSS OF COVERAGE

Loss of Coverage for Incapacitated Children

Dependent children, insured herein, who reach the limiting age, while covered hereunder, and are incapable of self-sustaining employment due to mental or physical handicap, may continue to be covered regardless of age. The Dependent child must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once every [Calendar Year].

Coverage for a handicapped Dependent child will end on the earliest of:

a) The date the child marries.
b) The date the child obtains self- sustaining employment.
c) The date the child ceases to be handicapped.
d) The date the child ceases to be chiefly dependent upon You.
e) Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days.
f) The date You refuse to allow Us to examine the child.

The date coverage under this Certificate would otherwise terminate.

Termination and Available Coverage After Termination -- COBRA

When a policyholder is required to comply with the federal law on continuation of coverage known as "COBRA," all eligible Insureds and dependents covered under this Certificate on the date before a qualifying event who would otherwise have lost coverage herein as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to your coverage while you have coverage under COBRA if the Policy would otherwise allow such a child to be covered by the Certificate. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the Insured, such child shall be considered a qualified beneficiary under the Certificate.

The Policyholder will notify the policy administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he becomes entitled to benefits under Title XVIII of the Social Security Act within 30 days of the occurrence of any of these events. You or Your covered dependent must notify the policy administrator within 60 days of his divorce or legal separation or when a dependent child is no longer eligible for coverage as defined in the Policy, in order for continuation coverage to be offered to the dependent.

The policy administrator will notify You or Your covered dependent of Your right to elect to continue coverage within 14 days from the date the policy administrator is first notified of any of the events described above. The election period shall begin no later than the date on which coverage terminates under the Policy due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

- The date coverage terminates under the Policy due to any qualifying event listed below, or

- The date the policy administrator sends notification to the Insured or covered dependent of his rights under this provision as described above.

Pursuant to the Trade Act of 1974, workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive Trade Act Assistance ("TAA") and may elect continuation coverage during a 60 day period that begins on the first day of the month in which he or she is determined to be a TAA eligible person. The person may elect coverage for himself and his family. The election must be made not later than 6 months after the date of TAA related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date which the coverage originally ended.

Benefits will be identical to those available under this Policy to all active Insureds and covered dependents that are similarly situated beneficiaries.

We require You and/or Your covered dependent pay for all or part of the cost for continuing the coverage, not to exceed 102% of the premium. Payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- The death of the participant,
- The divorce or legal separation of the participant from the covered dependent spouse,
- The participant becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or
- With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the Policy.

You and Your covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- Your employment with the policyholder terminates (except if due to the participant's gross misconduct), or

- You are laid off or Your working hours are reduced so as to render him ineligible for coverage as defined in the Policy.

If the You or Your covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

- The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;

- The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within the later of 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage, and before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within 30 days after the final determination is made that the person is no longer totally disabled; and

- The cost for coverage for months one through 18 will be at the rate of 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

- When You or Your dependent fails to make the required contribution (if any) to the plan administrator before the due date or within a grace period of 30 days;

- When the policyholder or covered dependent first becomes covered by any other group health Policy, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;

- When the policyholder ceases to maintain any group health Policy; or

- In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled.

A retired Insured and his or her spouse who would otherwise lose health coverage under the Policy after the policyholder files a Chapter 11 bankruptcy proceeding may continue coverage under the Policy until the death of the insured. Upon the death of the retired covered insured, his covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

If Your or Your dependent first becomes covered under another group health Policy or Medicare while covered hereunder, continuation coverage may continue only during the time that the new group health Policy contains any exclusion or limitation which relates to a pre-existing condition of the insured or dependent. Normal payments for this coverage must be made in order for continuation coverage to remain in effect.

Any other group health Policy will be considered the primary coverage and must always pay benefits before this Policy will consider a claim for benefits. The only exception is that the Policy will remain primary if the COBRA covered person is covered by Medicare by reason of end stage renal disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period, another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

CERTIFICATES OF CREDITABLE COVERAGE

We will issue Certificates of Creditable Coverage for each Insured whose coverage under the Group Policy is terminated. In addition, Certificates shall be issued when requested by an Insured, so long as such request is made within 24 months after cessation of coverage under the Group Policy. Such issuance will occur within a reasonable time.

SECTION 5 – GENERAL PROVISIONS

Grace Period: No Grace Period is allowed for the first premium. A Grace Period of 31 days is allowed for payment of each premium due after the first premium. We will continue Your insurance during the Grace Period. However, if We do not receive Your payment by the end of the Grace Period, Your coverage will terminate retroactive to the premium due date that You failed to pay the required premium. The Grace Period will not continue coverage beyond a date stated in the Termination Provisions.

Notice of Claim: Written notice of claim must be given to Us or Our authorized representative within 90 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Insured.

Claim Forms: We, upon receipt of written notice of claim, will furnish to the Claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the Claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us or Our authorized representative within 90 days after the covered loss. If proof of loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise required or the claim will be denied.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless this Certificate provides for periodic payment.

Payment of Claims: Benefits unpaid at the Insured's death may, at Our option, be paid either to such beneficiary or to the Insured's estate. All other benefits will be payable to the Insured.

If any benefit of this Certificate is payable to an Insured's estate, or to someone who is a minor or otherwise not competent to give a valid release, then We may pay up to $1,000 to any relative by blood, or connection by marriage to the Insured or to the beneficiary who is deemed by Us to be equitably entitled to it. Any such payment made in good faith shall fully discharge Us to the extent of such payment.

Unpaid Premium - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Physical Examination: We, at Our own expense, shall have the right and opportunity to examine an Insured as it may reasonably require while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 Years from the time written proof was required to be given.

[Subrogation: When benefits are paid to or for You or for a Dependent under the terms of the Group Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured or Dependent against any person who might be acknowledge to be liable by a Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by Us of the benefits we have paid for such hospitalization and treatment]

Assignment: You may assign all of Your rights, privileges and benefits under the Group Policy. We are not bound by an assignment until We receive and file a signed copy. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and Federal laws and the terms of the Group Policy.

Medical Claim Payment and Appeals:

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the Insured will be notified of the policy administrator's decision as soon as possible, but no more than 72 hours after the policy administrator receives the claim. If the treating physician classifies a claim as "urgent," the Policy will do so as well.

Extensions:

If information to support a review of an "urgent" claim is incomplete, the following will occur;

- The policy administrator will notify the Insured of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.

- The Insured has 48 hours to provide the missing information or the review of the "urgent" pre-service claim will be closed.

- The policy administrator will make its decision within 48 hours after it receives all necessary information. If a supplemental submission of information is deficient, the time frames begin again.

If an Insured appeals the denial of a pre-service "urgent" claim, the policy administrator must render a review decision as soon as possible, but no more than 72 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Policy:

If a policy administrator has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the policy administrator must notify the Insured of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the Policy has been amended to reduce or end coverage for the treatment, or when the Policy itself terminates.

Extensions of Treatment:

When an Insured requests an extension of an on-going course of treatment beyond that which the policy administrator has approved, the policy administrator must do the following:

- Make a decision about the extension as soon as possible; and

- Notify the Insured of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Managed Care Program

The managed care program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

Pre-Certification Process

Participants or their dependents with the benefit of a managed care program must have every inpatient hospital stay, other than maternity, certified. This is a participant-driven and participant-responsible program. The participant or agent for the participant may call or have the admitting physician or hospital call to certify the stay. Medical, surgical and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within two working days of admission. Maternity admissions for deliveries **do not** require certification. If the newborn baby stays longer in the hospital than the mother, the newborn's continued hospital stay must be certified.

Except in the case of maternity, at the time a medical, surgical or psychiatric inpatient hospital admission is planned, the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre-certification. A penalty per admission as shown in the schedule of benefits will be reflected to the participant if pre-certification requirements are not followed.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

- Plan participant name
- Company name
- Patient's name and age
- Admitting physician's name, address and phone number
- Name of hospital and address

Calls received after hours will be recorded, and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two working days of the emergency admission.

Concurrent Review

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The pre-certification unit staff will monitor the patient's progress throughout the hospital stay to assure discharge is not delayed by inadequate planning and that each day of confinement is medically necessary and appropriate.

The pre-certification staff will contact the hospital utilization review department or the admitting physician for information if additional days are needed beyond those days initially certified. This concurrent review will continue until the patient is discharged.

Inpatient days certified at admissions DO NOT determine the length of inpatient stay. Only the attending physician determines when a patient is to be discharged. The days anticipated at admission may not be needed, or an extension of inpatient days may be required. The physician determines this.

The appeal process is available for a patient's physician when a determination is made that additional days of inpatient care are not medically necessary.

Pre-Service Benefit Claim Review for Coverage

If the policy administrator requires that benefits for a service be predetermined prior to the service being provided, the Insured or the health care provider must submit a request for that pre-service benefit claim review to the policy administrator. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15-day period may be extended for another 15 days if it is necessary because of matters beyond the Policy's control, and if the policy administrator notifies the Insured of those circumstances and the expected date of the decision before the end of the first 15-day period.

- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the Insured 45 days to submit such information.

Normal Post-Service Health Claims

An Insured or health care provider must file a claim with the policy administrator within the time frames set out in the Policy. A claim will be considered to have been filed upon receipt by the policy administrator. The Insured will be notified within 30 days of receipt of a claim by the policy administrator as to the benefits to be paid for that claim.

Extensions:

- The 30-day period may be extended for 15 days if it is necessary due to matters beyond the control of the policy administrator, but the policy administrator will notify the Insured before the end of the 30-day period of those circumstances and the expected date of the decision.

- If more information is necessary to properly process the claim, a notice will be given within the 30-day period that the policy administrator can not meet the 30-day time frame. The notice will describe the missing information and give the Insured at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45-day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the Policy.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the policy administrator, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;

- A reference to any specific Policy provisions on which the determination is based;

- A description of any additional material or information necessary for the Insured to make the claim payable and an explanation of why such material or information is necessary;

- A description of the policy administrator's review procedures and the time limits which are applicable to such procedures, including a statement of the Insured's right to bring a civil action under Section 502(a) of ERISA;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Policy will provide that criterion free of charge upon request; and

- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the policy administrator will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the policy administrator will do the following:

- Allow an Insured 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the policy administrator at the address found in the summary Policy description;

- Allow an Insured the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Provide an Insured, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the Insured's claim for benefits;

- Provide for a review that takes into account all comments, documents, records, and other information submitted by the Insured relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Policy who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual
- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate policy administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained on behalf of the Policy in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

- Notify the Insured of the policy administrator's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the Insured's appeal, unless the policy administrator determines that special circumstances require an extension of time for processing the appeal.

SECTION 6 - COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does **not** include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Insured is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured is not an Allowable expense.

The following are examples of expenses that are **not** Allowable expenses:

(1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If an Insured is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If an Insured is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If an Insured is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that

provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because an Insured has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the [calendar year] excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When an Insured is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired member); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the [calendar year] is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to [calendar year] commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Member or Retired or Laid-off Member. The Plan that covers a person as an active member, that is, a member who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off member is the Secondary plan. The same would hold true if a person is a dependent of an active member and that same person is a dependent of a retired or laid-off member. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an member, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a [Calendar year] are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If an Insured is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The policy administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. The policy administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give The policy administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, The policy administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The policy administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by The policy administrator is more than it should have paid under this COB provision or for any amount paid out as a part of normal claim payments, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 7 – COVERAGE DESCRIPTIONS

All benefits under the Group Policy are shown in the Schedule of Benefits. The Schedule of Benefits also shows You the annual Plan Maximums, Lifetime Maximums, deductibles and co-payments per Insured for each benefit provided. The benefits are described and governed by the pages attached to and made a part of the Group Policy. For In-Network Eligible Expenses, benefits are payable at the percentage shown in the Schedule of Benefits for each benefit provided. For Out-of-Network Eligible Expenses, benefits are payable at the percentage shown for the Reasonable and Customary charges incurred.

[**INPATIENT CARE**
[If an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for Surgery, Physicians Services, Hospital Inpatient (including room and board, surgeon services and anesthesia), or Other Hospital Charges, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Benefits for Hospital care include Eligible Expenses incurred for Hospital Room and Board Expense, Intensive Care, and Other Hospital Charges for Miscellaneous Hospital Expense including for anesthesia and operating room; laboratory tests and X-rays; oxygen tent; drugs, medicines, dressings and other Durable Medical Equipment and other Medically Necessary and prescribed Hospital Expenses. If while confined as an inpatient an Insured requires the services of a Physician other than a Physician who perform surgery on, or administered anesthesia to, the Insured, We will pay a benefit for Physician Services.]

[We will also pay benefits for Surgical Expenses. Surgical Expense means charges by a Physician for:

a) a Surgical Procedure;
b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
c) usual postoperative treatment.

Surgical Procedure means:

- a cutting procedure;
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- radiotherapy (excluding radioactive isotope therapy)
- cutting operation for removal of a tumor;
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures;
- injection treatment of hemorrhoids and varicose veins;
- an operation by means of laser beam;
- casting;
- removal of a foreign body;
- drainage or aspiration;
- implant;
- catheter placement;
- microsurgery

The maximum benefit payable and co-payment amounts are shown in the Schedule of Benefits.

When an Assistant Surgeon is required to render technical assistance at an operation, the Schedule of Benefits will apply when services are provided by a network provider and if a non-network provider is used, the eligible expense for such services shall be limited to 25% of the reasonable and customary charge for the surgical procedure

If multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s).

Treatment performed outside the Hospital will be paid the same as if performed in a Hospital provided it would have been covered on an inpatient basis.]

[**BENEFITS FOR MATERNITY**

Maternity benefits are available to You and Your Spouse only.

When an Insured is confined to a Hospital as a resident inpatient for childbirth, We will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

a) 48 hours after a non-cesarean delivery; or
b) 96 hours after a cesarean section;

for the mother and the newborn infant(s), unless, at the mother's option, an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. We will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

In the event such earlier discharge occurs, at least one home visit will be available to the mother, and not subject to any deductibles, coinsurance, or co-payment.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) will be conducted within 24 hours following:

a) discharge from the Hospital; or
b) the mother's request; whichever is later.

Benefits include:

a) parent education;
b) assistance and training in breast or bottle feeding; and
c) the performance of any necessary maternal and newborn clinical assessments.]

One ultrasound test will be payable per pregnancy without any additional diagnosis. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary. In addition, for a female Insured over 35 Years of age, charges for the following tests may be considered Eligible Expenses:

- Amniocentesis/AFP Screening;
- Chromosome testing; and
- Fetal stress/non-stress tests.

This Provision is subject to all of the terms of the Group Policy.]

[**OUTPATIENT EXPENSE**
If, by reason of Injury or Sickness, an Insured requires Medically Necessary treatment in a Physician's office, Urgent Care Facility, or licensed ambulatory surgical facility, We will pay the benefits for the treatment and other office services related to such treatment. Treatment of pregnancy is on the same basis as any other Sickness. Benefits include diagnostic X-ray and laboratory examinations, and radiotherapy.

The Covered Percentage, deductible, co-payments and Plan maximums are shown in the Schedule of Benefits.

If the services are in connection with surgery and the Physician is the surgeon who performed the surgery, no benefits are payable under this Provision.

Benefits are payable for Eligible Expenses incurred for the following tests:

- pregnancy tests;
- CBC;

- Hepatitis B Surface Antigen;
- Rubella Screen;
- Syphilis Screen;
- Chlamydia;
- HIV;
- Gonorrhea;
- Toxoplasmosis;
- Blood Typing ABO;
- RH Blood Antibody Screen;
- Urinalysis;
- Urine Bacterial Culture;
- Microbial Nucleic Acid Probe;
- AFP Blood Screening;
- Pap Smear;
- Glucose challenge Test (at 24 weeks gestation); and
- PSA

[**PREVENTIVE CARE**
Benefits are payable for Eligible Expenses incurred by an Insured for the following preventive care. The charges must be incurred while an Insured is insured for these benefits. The annual maximum benefit and co-payment are shown in the Schedule of Benefits. The deductible provision does not apply to these benefits.

Cervical cytology screening and screening mammography

Eligible Expenses include the following:

a) in the case of benefits for cervical cytology screening, annual screening for women (18) eighteen Years of age and older. This coverage shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection, with examining and evaluating the Pap smear.

b) In the case of mammograms:

   1) a baseline mammogram for women at least age 35 but Younger than 40 Years of age.
   2) a mammogram every two Years for asymptomatic women age 40 but Younger than 50 Years of age or more often if recommended by the patient's Physician.
   3) A mammogram every Year for women age 50 or older.

Screening mammography means radiological examination of the breast of asymptomatic women for the early detection of breast cancer, which examination shall include:

a) a cranio-caudal and a medial lateral oblique view of each breast; and
b) a licensed radiologist's interpretation of the results of the procedure. Screening mammography shall not include diagnostic mammography, additional projections required for lesion definition, breast ultrasound, or any breast interventional procedure. Screening mammography shall be performed by a mammogram supplier who meets the standards of the Federal Mammography Quality Standards Act of 1992.

Routine Annual Examination for Adult Insured: Benefits are also payable for one annual check-up to a Physician per Insured for a wellness visit. Benefits include all related charges up to the amount shown in the benefit schedule.

Routine Well Child Care Benefits: Benefits are payable for child wellness services which are rendered during a periodic review are covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one visit. Covered services include: medical history; measurement of height, weight and head

circumference; testing of blood pressure; sensory screening including vision and hearing; hereditary and metabolic screening in accordance with state law; developmental/behavioral assessment; immunizations consistent with prevailing American Academy of Pediatric Committee statements; tuberculin test; hematocrit or hemoglobin; urinalysis; and anticipatory guidance.]

[EMERGENCY ROOM SERVICES
Subject to any co-payment, if an Insured incurs Eligible Expenses in a Hospital Emergency Room for treatment of a medical emergency due to Injury or Sickness, we will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers. The co-payment is waived if the Insured is admitted to the Hospital as an inpatient.]

[SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are payable if an Insured incurs Eligible Expenses for treatment of a medical emergency due to an Accident, we will pay the benefits shown on the Schedule of Benefits on the percentages shown for In-Network or Out-of-Network Providers.]

[CARDIAC, OCCUPATIONAL, PHYSICAL, PULMONARY, SPEECH THERAPIES, AND CHIROPRACTIC CARE
Subject to any co-payment and deductible requirements, if an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for cardiac, occupational, physical, pulmonary, and speech therapies and chiropractic care, we will pay the benefits shown in the Schedule of Benefits. The treatment must be for rehabilitation, must be Medically Necessary, and be prescribed by a Physician.

These services/therapies each has a benefit maximum of 20 visits per Insured, per [plan year] whether provided on an out-patient or inpatient basis. The benefit maximum renews each [plan year].

Each treatment date counts as one visit for each service provided, even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides You with physical therapy and occupational therapy on the same day, the services are counted as one visit for physical therapy and one visit for occupational therapy. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied toward the maximum benefit limit.

Physical therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a neuromuscular condition that can be significantly improved within a 6-month period of time.

We pay for physical therapy performed by:

- A doctor of medicine, osteopathy or podiatry
- A dentist for the oral-facial complex
- An optometrist for services for which they are licensed
- A certified nurse practitioner
- A licensed physical therapist under the direction of a Physician
- Other individuals under the direct supervision of a licensed physical therapist, MD or DO or
- A licensed independent physical therapist

Services do not include:

- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program

- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy
- Physical therapy performed by a chiropractor except mechanical traction

Speech and language pathology services must be:

- Prescribed by a Physician licensed to prescribe them
- Given for a condition that can be significantly improved within 6-months
- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist.

The clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

Occupational Therapy must be:

- Prescribed by a Physician licensed to prescribe it and
- Given for a condition that can be significantly improved within 6 months and
- Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of in which he or she practices). The occupational therapy assistant must be under the direct supervision of a registered occupational therapist, who cosigns all assessments and patients' progress notes.

Services do **not** include:

- Occupational therapy examinations or evaluations without an occupational therapy treatment plan and where there is no progress
- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- Recreational therapy

Cardiac Rehabilitation Therapy includes intensive monitoring (EKGs) and/or supervision during exercise in a Physician-directed clinic (one in which a Physician is on-site).

Chiropractic services include manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, applications of heat or cold by a Physician or chiropractor.

Pulmonary Therapy includes respiratory therapies prescribed by a Physician as Medically Necessary treating Insureds with chronic breathing problems that include:

- Asthma
- Emphysema
- COPD (Chronic Obstructive Pulmonary Disease)
- Sarcoidosis
- Cystic Fibrosis
- Pulmonary Fibrosis
- Chronic Bronchitis
- Interstitial lung Disease

- Pre and post lung volume reduction surgery
- Bronchiectasis
- Other cardiopulmonary disorders]

[**TRANSPLANT RELATED EXPENSES**
Subject to any deductible payment, if an Insured incurs Transplant related Eligible Expenses, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Allogenic Transplants
We will pay the Reasonable and Customary expenses incurred for allogenic transplants as follows:

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is: a) A first degree relative and matches at least four of the six important HLA genetic markers with the patient; or b) Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This Provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.) Harvesting and storage will be covered if it is not covered by the donor's insurance. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants
We will pay the Reasonable and Customary expenses incurred for autologous transplants as follows:

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of "Tandem Transplant" in the Definitions Section.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Aplastic anemia
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency Disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)

- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Megakaryocytic thrombocytopenia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucolipidoses (e.g., Gaucher's Disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's Disease (high risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

NOTE: In addition to the conditions listed above, We will pay for services related to, or for high dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage to antineoplastic drugs when a state law requires that these drugs, and the reasonable cost of their administration, be covered.

We do **not** pay the following for bone marrow transplants:

- Services that are not Medically Necessary
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- An allogeneic tandem transplant
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

Specified human Organ Transplants
When performed in a designated facility, We pay for transplantation of the following human organs:

Combined small intestine-liver
Heart
Heart-lung(s)
Liver
Lobar lung
Lung(s)
Pancreas
Partial liver
Simultaneous pancreas-kidney
Small intestine (small bowel)

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided while coverage is in force under the Group Policy and such services must begin five days before and end one Year after the organ transplant to be covered.

When directly related to the transplant, We pay for:

Facility and professional services
Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed.

Medically Necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during a benefit period and is the direct result of the organ transplant surgery.

We do **not** pay for the following for specified human organ transplants:

- Services that are not covered benefits under the Group Policy
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
- Anti-rejection drugs that do not have a Food and Drug Administration marketing approval
- Transplant surgery and related services that are not performed in a designated facility. You must pay for the transplant surgery and related services You receive in a non-designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and Hospitalization
- Services prior to Your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under the Group Policy
- Experimental transplant procedures. See the definition of experimental treatment

SECTION 8- EXCLUSIONS AND LIMITATIONS

The following are not Eligible Expenses and not covered under the Group Policy:

1. [Injury arising out of or in the course of employment, or activity for wage or profit, or which is compensable under Workers' Compensation or Occupational Disease Act or Law.]
2. [Experimental or investigational services, drugs, or supplies except to the extent required by law;]
3. [Educational testing or training related to learning disabilities or developmental delays;]
4. [Custodial care or personal items;]
5. [Any expense incurred before the Effective Date of an insured's insurance under the Policy or after the termination date of an Insured's insurance.]

6. [Eye surgery to correct refractive errors;]
7. [Therapy, supplies, or counseling for sexual dysfunctions]
8. [Performance, or lifestyle enhancement drugs or supplies]
9. [Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered]
10. [Routine physical, vision, or hearing exams, immunizations, or other preventive services or supplies, except to the extent that coverage is specifically provided under the Group Policy;]
11. [Dental care except for Injury to sound natural teeth;]
12. [Elective surgery;]
13. [Cosmetic Surgery other than reconstructive Surgery incidental to or following surgery resulting from trauma, infection, or other Diseases of the involved part; or reconstructive surgery because of a congenital Disease or anomaly;or according to the requirements of the Women's Health and Cancer Rights Act]
14. [Speech therapy except as otherwise specifically covered under the Group Policy;]
15. [Inpatient or outpatient treatment of alcoholism, drug abuse, and mental illnesses; except where required by law]
16. [Private duty nursing;]
17. [An Injury sustained while the Insured is legally intoxicated or under the influence of alcohol as defined by the jurisdiction where the Accident occurred;]
18. [Charges made to treat a Sickness or Injury sustained while flying as a pilot or crew member;]
19. [Voluntary sterilization procedure or the reversal of a sterilization procedure;]
20. [Weight control services including surgical procedures, medical treatments, weight control/loss programs; food supplements or exercise programs or equipment; and]
21. [Intentionally self inflicted injury or action unless the result of a medical condition]
22. [War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.]
23. [Services and supplies not medically necessary, recommended or approved for the diagnosis, care, or treatment of the disease or injury involved by the treating physician.]
24. [Charges made for: manipulative (adjustive) treatment; or treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.]
25. [Prescription drugs and medicines prescribed by a physician [on an outpatient basis]]
26. [Charges in excess of the Recognized Charge, based on the 90th percentile of the Medicode Medical Data Research Tables.]
27. [Charges for any treatment received while in a skilled nursing facility will not be covered.]
28. [Charges for any treatment for Home Health Care, except as covered under maternity.]
29. [Transportation charges, including ambulatory services.]
30. [Charges for biofeedback.]
31. [Any Treatment received under hospice care.]
32. [Elective or voluntary abortions, except in the case of rape, incest or congenital deformities.]
33. [Charges for Prosthetics and/or orthotics.]
34. [Charges for Temporomandibular Joint Disorder (TMJ).]

PRE-EXISTING CONDITIONS: Expenses incurred for treatment of Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy.

Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy. This limitation will **not** apply if:

a) The individual seeking coverage under the Group Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage Credit will be given for the time the individual was covered under prior Creditable Coverage that is not separated by a break in coverage of 63 days or more; and
b) The individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

Pre-existing Conditions does **not** apply to:

a) a newborn Dependent child; or
b) a child adopted by the Insured or placed with the Insured for adoption, if adoption or placement for adoption occurs while covered under the Group Policy.

CREDIT FOR PRIOR COVERAGE: An Insured whose coverage under prior Creditable Coverage ended no more than 63 days before the Insured's Effective Date under the Group Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break. The Insured must provide proof of prior Creditable Coverage.

Creditable Coverage means coverage under any of the following:

a) Any individual or Group Policy, contract, or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured member Plan, or any other entity, and that arranges or provides medical, Hospital and surgical coverage not designed to supplement other private or governmental plans;
b) The Federal Medicare Program pursuant to Title XVIII of the Social Security Act;
c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
d) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);
e) a medical care program of the Indian Health Service or of a tribal organization;
f) a state health benefits risk pool;
g) a health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) Federal Employees Health Benefits Program (FEHBP);
h) a public health plan as defined under section 5(e) of the Peace Corps Act (22 U.S.C.A. Section 2504(e)); or
i) any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the Federal Public Health Services Act (42 U.S.C. Section 300gg(c)).

Creditable Coverage includes continuation or Conversion coverage but does **not** include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

ENROLLMENT FORM

Please Mail To: Post Office Box 2086
Fort Mill, South Carolina 29716-2086

(866)-543-0896

FOR OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Mid Med		
Endorsement:		
EFFECTIVE DATE:		

[Member] Name/Owner (First, MI, Last)	Social Security Number	Gender	Date of Birth

Street Address	City	State	Zip

[Policyholder]/Group #	Job Class	Location	Date of Hire

Hours Worked	Daytime Phone No.

Are you actively at work? ☐ YES ☐ NO

ENROLLMENT INFORMATION

☐ **New Enrollment** ☐ **Change** **Special Circumstances:** Date: _____ Reason: _____	**Plan Selection:** ☐ Basic ☐ Enhanced ☐ Other:_____
Coverage Level (choose one): ☐ [Member] Only ☐ [Member] Plus One ☐ [Member] and Family	
Monthly Premium: $ _____ **Section 125:** ☐ Yes ☐ No	

DEPENDENT INFORMATION

Please complete for all covered dependents.

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

Relationship	First Name	M.I.	Last Name	S.S.#	Gender	Date of Birth	Full Time Student

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury which was diagnosed or treated by a Doctor prior to the Covered Person's Effective Date of coverage for the Covered Person with consultation, advice or treatment by a Doctor within 6 months prior to the Effective Date of coverage for the Covered Person.

This is Important - Please Read
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: _____

Date of Signature: _____

- **YES, I DO WANT THIS COVERAGE**

• I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.

• All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.

• I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.

• Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

• Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).

• Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty or insurance fraud.

• I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: $ _____

[Member] Acceptance: _____

Date of Signature:_____

- **No, I decline coverage for myself and/or spouse**

☐ I decline coverage because I am covered under another group policy of medical insurance.

☐ I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.

☐ I decline coverage but I do not have another group policy of medical insurance.

(Member) Declination: _____

Date of signature: _____

Agent Signature: _____ Date of Signature: _____

CONTINENTAL AMERICAN INSURANCE COMPANY
2802 Devine Street, Columbia, SC 29205
800-433-3036

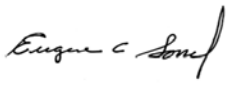
Group Hospital-Medical-Surgical Expense Policy

In return for the payment of premium expressed in the Schedule of Benefits, Continental American Insurance Company, a stock company herein called We, Us, or Our, agrees with the Policyholder to pay the benefits of this Group Policy to the persons insured hereunder, subject to the terms and conditions that follow. This Group Policy is executed as of the Policy Date that is the date of issue. This Group Policy is delivered in, and subject to the laws of the Jurisdiction in which it is issued.

PLEASE READ THIS GROUP POLICY CAREFULLY FOR FULL DETAILS.

This Group Policy is a legal contract and is issued in consideration of the Group Application of the Policyholder, a copy of which is attached, and of the full payment of premiums due. The following pages, including any riders, endorsement, schedule pages, Insured's enrollment forms, applications or amendments, form a part of this Group Policy.

In Witness Whereof, We have caused this Group Policy to be signed by



President

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Non-Participating

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

Schedule of Eligibility

Name of Policyholder: [AC Company]

Address: [123 Any Street, Any City, Any State]

Policy Number: [1234]

Policy Date: [September 1, 2008] All coverage begins and ends at 12:01 AM at the Policyholder's address.

Policy Anniversary: [ ]

Policy Year: The 12 consecutive month period starting on the Policy Date (or the Policy Anniversary) for subsequent Policy Terms.

Jurisdiction: [Any State]

Eligible Classes:

Eligible Participating Entities:

The following individuals are eligible to become insured under this Group Policy:

[Class - Description of Class as defined by the Employer/Policyholder]

Schedule of Premiums

[Employee Only	$ 55.17]
[Employee Plus One	$ 122.47]
[Employee& Family	$ 195.37]

POLICY PROVISIONS

Entire Contract; Changes: This Group Policy, including the endorsements, application, enrollment form, Certificate and the other attached papers, if any, constitutes the entire contract of insurance. No change in this Group Policy shall be valid until approved by Our Executive Officer and unless such approval be endorsed hereon. No agent has authority to change this Group Policy or to waive any of its Provisions.

All statements made by the Policyholder or Insured are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be Used as a defense to a claim unless a copy of the instrument containing the statement is in writing and signed by the Policyholder or the Insured, if applicable, and is or has been furnished to such Policyholder or Insured, if applicable.

Incontestability: After two (2) Years from the Policy Effective Date no statement, except a fraudulent misstatement, will cause the Group Policy to be contested.

Policy Period: The premium due for this Group Policy shall be remitted to Us by an Officer of the Policyholder authorized to remit premiums. The premium bases and rates are as stated in the Schedule of Premiums are due and payable [monthly] on the first day of each [month].

(1) **Change of Premium Rates:** We may, by written notice to the Policyholder at least 31 days in advance, change the rate at which further premiums, including the one then due, shall be computed. The new rate will not be based on this Group Policy's loss experience.

(2) **Grace Period:** A Grace Period of thirty-one days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy will continue in force, subject to Our right to cancel in accordance with Provision entitled "Cancellation". The Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force.

Certificate of Insurance: We shall issue to the Policyholder for delivery to each Insured, an individual Certificate that shall state the essential features of Insurance to which such a person is entitled and to whom benefits are payable when his or her insurance becomes effective.

Data Furnished by the Policyholder: If requested to do so by Us, the Policyholder shall furnish Us with the names of all persons initially insured, of all new persons who become insured, and of all Insureds whose insurance is cancelled, together with the data necessary for the calculation of premium. Failure on the part of the Policyholder to furnish the name of an Insured to Us shall not invalidate his or her insurance; nor shall failure on the part of the Policyholder to report termination of insurance of a person continue such insurance in force beyond the date of termination.

Examination and Audit: We shall be permitted to examine the Policyholder's records relating to the Group Policy at any time during the Policy term and within three Years after expiration of the Policy or until final adjustment and settlement of all claims hereunder, whichever is later.

Cancellation: After the Policy has been continued beyond its original term, the Policyholder may cancel this Policy or the Participating Entity may cancel its program under this Policy any time by written notice delivered or mailed to Us effective on receipt or on such later dates as may be specified in the notice. Such notice must be provided at least 31 days prior to the cancellation date. In the event of such cancellation by the Policyholder, We shall promptly return on a pro rata basis the unearned premiums paid, if any, and the Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid. Such cancellation shall be without prejudice to any claim origination prior to the Effective Date of such cancellation.

Renewability: This Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force.

Additional Insureds: Newly eligible persons and their Dependents may be added to the Group, in accordance with the terms of the Policy.

Not in Lieu of Worker's Compensation: This Group Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation insurance.

Assignment: The Group Policy is [non-]assignable. The Insured may [not] assign any of the Policyholder rights, privileges or benefits under the Group Policy [to a PPO network provider of services only].

INCORPORATED PROVISION

The Provisions of the attached Certificate and all amendments to this Group Policy after its Effective Date are incorporated into and made part of this Group Policy.

The Provisions listed below are shown in the Certificate and are hereby incorporated into and made a part of this Group Policy.

Schedule of Benefits
Definitions
Effective Date of Coverage
Conversion
General Provision
Coverage Descriptions
Exclusions and Limitations

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

GROUP HOSPITAL-MEDICAL-SURGICAL EXPENSE INSURANCE
CERTIFICATE OF INSURANCE

Continental American Insurance Company, herein referred to as We, Us, or Our, certifies that the person named in the Certificate Schedule, herein referred to as You, is insured for the benefits described in this Certificate. This insurance is subject to the eligibility, any applicable Waiting Period, and Effective Date requirements contained in the Group Policy.

Your insurance is effective at 12:01 a.m. Standard Time at the address of the Group Policyholder on the Certificate Effective Date shown in Your Certificate Schedule.

TEN DAY FREE LOOK

You may cancel the insurance described in this Certificate at any time during the 10 day period after You receive this Certificate. Mail this Certificate with Your written request for cancellation to Our Agent or Us. We will promptly refund the premium paid and the insurance will be void.

IMPORTANT NOTICE

This Certificate is a summary of the Group Policy Provisions that affect Your insurance. It is merely evidence of the insurance provided by such Policy. The Group Policy is a contract between the Group Policyholder and Us. It may be changed or ended without notice or consent of any Insured.

This Certificate replaces any Certificate previously issued by Us to You under the Group Policy.

The benefits described in this Certificate are provided by the Group Policy Number shown on the Schedule and issued to the Group Policyholder whose name is shown on the Schedule.

READ YOUR CERTIFICATE CAREFULLY.

THIS COVERAGE PROVIDES LIMITED BENEFITS UP TO A CALENDAR YEAR MAXIMUM. PLEASE REVIEW YOUR SCHEDULE PAGE FOR BENEFITS.

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

TABLE OF CONTENTS

SECTION

SECTION 1- SCHEDULE OF BENEFITS

Insured - [John A. Doe]
Effective Date - [December 1, 1995]
Initial Premium - [$5.00 Monthly]
Group Policy Holder - [ABC Company]
Group Policy Number - [895]
Certificate Number - [51491]
First Renewal Date - [January 1, 1996]

Plan of Insurance	**In-Network**	**Out-of-Network**
Lifetime Plan Maximum [$5,000 - unlimited] per Insured		
Annual Plan Maximum [$5,000 - unlimited] per Insured		
[Calendar Year] Deductible (Individual/Family)	[$0-$100,000 / $0 - $300,000]	[$0-$100,000 / $0 - $300,000]

[Calendar Year] Deductibles apply to every expense listed below, unless otherwise noted.
Co-payments are not applied to the [Calendar Year] Deductible.
Any paid deductible is used to satisfy both in-network and out-of network requirements

In-Patient Care		
[Surgery-Inpatient, Physicians Services	[Surgery In-patient MD 20% - 100%]	[Surgery In-patient MD 20% - 100%]
[Hospital Inpatient (Facility)	[Hospital In-patient (Facility) 20%-100%]	[Hospital In-patient (Facility) 20%-100%]
[Other Hospital Charges (Including hospital based Professional charges) See Note (A)	[20%-100%]	[20%-100%]
[Physician Services (Inpatient visits)	[20%-100%]	[20%-100%]
[Maternity Care (You and covered Spouse only)	[20%-100%]	[20%-100%]
Out-patient Care -See Note (B)		
[Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	[$0-$150] Co-pay Then [20% - 100%]	[20% - 100%]
[Other Office Services provided during the Office Visit	[20% - 100%] No Calendar Year Deductible	[20% - 100%]
[Urgent Care Facility	[20% - 100%]	[20% - 100%]
[Surgery, Out-patient	[20% - 100%]	[20% - 100%]
[Maternity Care (You and covered Spouse only)	[20% - 100%]	[20% - 100%]
[Supplemental Accidental Benefit	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]]
[Emergency Room (if not admitted in-patient)	[20% - 100%] after [$0-$1000] Co-pay	[20% - 100%] after [$0-$1000] Co-pay]
[Cardiac, Occupational, Physical, Pulmonary & Speech Therapies and Chiropractic See Note (C)	[20% - 100%]	[20% - 100%]
[Transplant-Related Expenses	[0% - 100%]	[0% - 100%]
[Routine Physical Exams, Pap Smears, Mammograms; PSA's See Note (D)	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit]	[20% - 100%]] No Calendar Year Deductible [$25-$750] Calendar Year Benefit]]

[Routine Well Child Care	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit	[20% - 100%] No Calendar Deductible] [$25-$750] Calendar Year Benefit]]
Others		
Mental Health	Not covered unless required by law	Not covered unless required by law
Substance Abuse Care	Not covered unless required by law	Not covered unless required by law

NOTES: (A): Other Inpatient Hospital Charges are subject to [$5,000-unlimited] Annual Maximum per Insured.
(B): Outpatient Care is subject to [$5,000-unlimited] Annual Maximum per Insured.
(C): Subject to [5-60] visits per category per [Calendar Year] per Insured.
(D): Routine Physical Exams include all related charges up to [$25-unlimited] Calendar Benefit.

Managed Care Program

Except for maternity admission, a participant or covered dependent is required to call a toll-free number upon learning of a future hospital admission, or to call within two working days after an emergency admission. This toll-free number is on the back of the plan's medical identification card. If this provision is not followed, then hospital charges and all charges related to the hospital admission will be subject to a [$250] per admission penalty, in addition to any deductible that may apply. Maternity admissions **do not** require certification. However, if the newborn baby stays longer in the hospital than the mother, the newborn's continuing hospital stay must be certified. Pre-certification of a hospital stay for medical necessity is not a guarantee of coverage or of payment of benefits. Coverage for benefits will only be determined when the claim is received, eligibility is verified, and its determined that the benefits were in effect as of the time of service.

A Preferred Provider Organization (PPO) is an organization in which a Group of Hospitals and Physicians have agreed to provide medical care services to Insureds. The PPO for the Policy will be selected by Us. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to Policy Provisions. These benefits are payable at the In-Network benefit level. An Insured has the option to use a PPO Provider or a non-PPO Provider. If an Insured uses a non-PPO, benefits are payable at the Out-of-Network benefit level described above and subject to the out-of network deductible and coinsurance. If a PPO provider is used, auto assignment of benefits would apply unless payment in full is provided at claim submission.

For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the non-PPO level. However, if such treatment is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

Benefits payable under the Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its Providers and be paid directly to the Provider.

Benefits payable under the Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the Providers.

SECTION 2 – DEFINITIONS

Whenever used in the Group Policy:

Accident means: an occurrence which (a) is unforeseen; (b) is not due to or contributed to by a Sickness of any kind; and (c) causes Injury.

Actively-at-work means that on the day that coverage under the plan would begin, an employee, or self employed independent contractor, is not absent from work, or if he or she is absent from work, the absence is not related to the health of the employee.

[**Allogeneic (Allogenic) Transplant** means: a procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.]

Allowable Charges means: the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

[**Autologous Transplant** means: a procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.]

Complications of pregnancy means: the following:

a) Conditions requiring Hospital Confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; but the term shall **not** include: false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b) Ectopic pregnancy which is terminated.

[**Calendar Year:** A period of one year that starts on January 1 and ends at midnight on December 31st.]

Insured means: a person who is covered for benefits under the Group Policy while it is in effect and those Dependents covered for benefits under the Group Policy.

Deductible/Deductible Amount means: the dollar amount of Eligible Expenses an Insured must pay during each [Calendar Year] before benefits become payable.

Dependent means: Your:

a) married Spouse who lives with You and is under age 65; or
b) unmarried natural child, step child, foster child, adopted child or a child during the pendency of adoption who is not eligible for insurance as an Insured under the Group Policy and who:

    (1) is less than 19 Years old and is Dependent on You; or
    (2) is less than 25 and enrolled in an accredited school as a full-time student at a post-secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to Injury or Sickness. Such child will be covered so long as the coverage of the insured parent or guardian continues in effect and the child remains a Dependent of the parent or guardian.

(3) Becomes incapable of self-support because of mental retardation or physical handicap while insured under the Group Policy and prior to reaching the limiting age for Dependent children. The child must be Dependent on You for support and maintenance. We must receive proof of incapacity. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time after the child attains age [18-21] ; or
(4) Is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent does **not** include:

a) Your grandchild (except where required by law); or
b) A child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b) (2) above.

If a Dependent is eligible to be an Insured, he or she is not eligible as a Dependent.

In the event both parents of a Dependent child are Insureds, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

[Designated Facility means: a facility that We determine to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to You and Your Physician upon request.]

[**Durable Medical Equipment** consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, Hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Physician and be required for therapeutic use.

The following items are **not** considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair gliders, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.]

Elective Treatment means: medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Insured's Effective Date of coverage.

Elective treatment includes, but is not limited to; tubal ligation; vasectomy, breast reduction unless as a result of mastectomy; sexual reassignment surgery; sub mucous resection and /or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; learning disabilities; immunizations; botox injections, treatment of infertility and routine physical examinations.

Eligible Expense as used herein means: a charge for any treatment, service or supply which is performed or given under the direction of a Physician for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Group Policy is in force as to the Insured except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Service means: Health Care Services necessary to screen and stabilize an Insured in connection with an Emergency Medical Condition.

Experimental/Investigational means: a drug, device or medical care or treatment that meets the following:

a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a familiar function, if Federal or state law requires such review and approval;
d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

Geographic area means: the zip code in which the services, procedure, devise, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, devise, drug or supply.

Hospital means: a facility which meets all of these tests:

a) it provides in-patient services for the care and treatment of injured and sick people; and
b) it provides room and board services and nursing services 24 hours a day; and
c) it has established facilities for diagnosis and major surgery; and
d) it is supervised by a Physician; and
e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
f) it is accredited by the Joint Commission of Accreditation of Healthcare Organizations.

Hospital does **not** include a place run mainly: (a) as a convalescent home; or (b) as a nursing home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders or substance abuse or; (d) as a place for the aged unless written authorization is received.

The term Hospital includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Insured; (b) an ambulatory surgical center or ambulatory medical center (c) a mental health Hospital if supervised and licensed by the Department of Mental Health; and (d) a birthing facility certified and Licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital Confinement/Hospital Confined means: a stay of at least 18 consecutive hours or for which a room and board charge is made.

Immediate Family Member(s) means: a person who is related to the Insured in any of the following ways: Spouse, brother-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Injury means: bodily Injury due to an Accident which:

a) results solely, directly and independently of Disease, bodily infirmity or any other causes: and
b) All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

[**Intensive Care Unit** means: a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.]

Medical Necessity/Medically Necessary means: that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will **not** be considered as Medically Necessary if it:

a) is provided only as a convenience to the Insured or Provider; or
b) is not the appropriate treatment for the Insured's diagnosis or symptoms; or
c) exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
d) is Experimental/Investigated or for research purposes; or
e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual Center for Medicare and Medicaid Services Issues Manual; or
h) can be safely provided to the patient on a more cost-effective basis such as outpatient, by different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental or Nervous Disorder(s) means: any condition or Disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder (other than those conditions deemed serious Mental Illness, as defined in the Group Policy) on the date the medical care or treatment is rendered to an Insured.

One Sickness means: a Sickness and all recurrent and related conditions that are sustained by an Insured.

[**Orthopedic Brace and Appliance** means: a supportive device or appliance used to treat a Sickness or Injury.]

Personal Item means: an item that is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

Physician as used herein means:

a) legally qualified person licensed by the state in which he or she practices; and
b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and
c) certified nurse midwives and licensed midwives while acting within the scope of that certification.

The term Physician does **not** include an Insured's Immediate Family Members.

[**[Plan Year]** means: the consecutive 12-month period starting with the Effective Date shown in the Schedule of Benefits. Subsequent [Plan year] run from the anniversary date of Your Effective Date.]

Pre-existing condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the enrollment date. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

Pregnancy shall not be considered a pre-existing condition hereunder

A newborn child, a child placed for adoption, or a newly adopted child under age 18 who begins dependent coverage hereunder within 30 days of birth, placement for adoption, or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

Reasonable and Customary means: the charge, fee or expense which is the smallest of the:

a) actual charge;
b) charge usually made for a covered service by the Provider who furnishes it;
c) negotiated rate, if any;
d) prevailing change made for a covered service in the geographic area by those of similar professional standing as determined by the 90th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies.

Sickness means: a disease or illness including related conditions and recurrent symptoms of the Sickness that begins after the Effective Date of an Insured's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or related cause are considered one Sickness.

Sound Natural Teeth means: natural teeth, the major portion of the individual tooth that is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

Spouse means: Your legal Spouse [or Domestic Partner if recognized by state law.].

Tandem Transplant means: a procedure that requires the patient to undergo two planned autologous stem cell transplants within 6 months. Stem cells are collected once before initial high intensity chemotherapy or radiation therapy. Half of the stem cells are thereafter used for an initial stem cell transplant and the second half are used after recovery from the first procedure.

[Totally Disabled and Total Disability means: with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, it means that the Dependent cannot perform the normal activities of a person of like age and sex.]

[**Urgent Care Facility** means: a licensed facility that provides a variety of medical, surgical and/or pediatric services on an ambulatory emergency or non-emergency basis where the conditions being treated do not require inpatient confinement. Treatment must be under the supervision of a Physician and the facility must include a resident graduate nurse on staff.]

Waiting Period means: The continuous length of time that You must be Actively at Work before becoming eligible to enroll for coverage.

SECTION 3 – EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND ENROLLMENT

You: You are eligible for coverage when You satisfy the Waiting Period, complete a valid [application][enrollment form], and pay the initial premium.
Dependent: A Dependent is eligible for coverage on the later of the date You:

a) become eligible for insurance; or
b) acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the later of the Certificate Effective Date if Your Spouse is Your legal Spouse on that date or the date of the marriage to You.

Natural Child: From moment of birth.

Adopted Child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.

Stepchild: On the date the child begins residing in Your home.

Special Enrollees

You shall be a ***special enrollee*** provided:

- You or your dependant lost other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage, reduction in benefits of the other coverage or you voluntarily terminate the coverage); or,

- Employer contributions toward such other coverage were terminated; or,

- You or your dependents were covered under a COBRA continuation provision and the COBRA continuation period has been exhausted.

Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a ***special enrollee***.

An otherwise eligible employee who is not covered by the plan, an otherwise eligible employee and dependent who are not covered by the plan, or a participant's dependent who is not otherwise covered by the plan may apply for coverage under the plan as a result of the acquisition of a new dependent by the employee and shall be a ***special enrollee*** provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent.

A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Coverage for a ***special enrollee***, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall begin as of the first day of the calendar month following a timely enrollment request.

EFFECTIVE DATE

Insured: If You enroll within the Enrollment Period after first becoming eligible to enroll for coverage, Your insurance will take effect on the later of:

a) The date You enroll; or
b) The date You satisfy the Waiting Period, if any,

No coverage will go into effect until You have satisfied the Waiting Period.
Insured Deferred Effective Date: If an eligible person is not Actively at Work on the date his or her insurance under the Group Policy is otherwise to take effect, such insurance will take effect on the day after such person returns to active work.

Dependent, except Dependents Acquired after the Effective Date: The Effective Date of coverage for a Dependent is shown in the Schedule of Benefits. In no event will Dependent coverage become effective prior to the date Your coverage becomes effective.

RENEWABILITY

This Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew the Group Policy because of any change in an Insured's health or physical condition. We may, at Our option, decline to renew the Certificate if We decline to renew the Group.

Unless the Certificate is renewed as stated in this Provision, coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will send written notice of any termination or non-renewal including the reasons for non-renewal or termination of this Certificate by certified mail not less than 60 days prior to the non-renewal or termination, except for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

TERMINATION

An Insured's coverage will terminate at 12:01 a.m. Standard Time at Your home on the earliest of the following:

a) The date the Group Policy terminates or the date a Policyholder or sponsoring entity terminates coverage under the Group Policy;
b) The date coverage is terminated by Us for all certificate holders in Your state;
c) The date We receive Your written request to have Your insurance terminated;
d) The end of the period for which premium is paid, subject to the Grace Period;
e) The date an Insured enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces.
f) With respect to a Dependent Spouse, the date the Spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.
g) With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

SECTION 4 - LOSS OF COVERAGE

Loss of Coverage for Incapacitated Children

Dependent children, insured herein, who reach the limiting age, while covered hereunder, and are incapable of self-sustaining employment due to mental or physical handicap, may continue to be covered regardless of age. The Dependent child must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once every [Calendar Year].

Coverage for a handicapped Dependent child will end on the earliest of:

a) The date the child marries.
b) The date the child obtains self- sustaining employment.
c) The date the child ceases to be handicapped.
d) The date the child ceases to be chiefly dependent upon You.
e) Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days.
f) The date You refuse to allow Us to examine the child.

The date coverage under this Certificate would otherwise terminate.

Termination and Available Coverage After Termination -- COBRA

When an employer is required to comply with the federal law on continuation of coverage known as "COBRA," all eligible Insureds and dependents covered under this Certificate on the date before a qualifying event who would otherwise have lost coverage herein as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to your coverage while you have coverage under COBRA if the Policy would otherwise allow such a child to be covered by the Certificate. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the Insured, such child shall be considered a qualified beneficiary under the Certificate.

The Employer will notify the policy administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he becomes entitled to benefits under Title XVIII of the Social Security Act within 30 days of the occurrence of any of these events. You or Your covered dependent must notify the policy administrator within 60 days of his divorce or legal separation or when a dependent child is no longer eligible for coverage as defined in the Policy, in order for continuation coverage to be offered to the dependent.

The policy administrator will notify You or Your covered dependent of Your right to elect to continue coverage within 14 days from the date the policy administrator is first notified of any of the events described above. The election period shall begin no later than the date on which coverage terminates under the Policy due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

- The date coverage terminates under the Policy due to any qualifying event listed below, or

- The date the policy administrator sends notification to the Insured or covered dependent of his rights under this provision as described above.

Pursuant to the Trade Act of 1974, workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive Trade Act Assistance ("TAA") and may elect continuation coverage during a 60 day period that begins on the first day of the month in which he or she is

determined to be a TAA eligible person. The person may elect coverage for himself and his family. The election must be made not later than 6 months after the date of TAA related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date which the coverage originally ended.

Benefits will be identical to those available under this Policy to all active Insureds and covered dependents that are similarly situated beneficiaries.

We require You and/or Your covered dependent pay for all or part of the cost for continuing the coverage, not to exceed 102% of the premium. Payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- The death of the participant,
- The divorce or legal separation of the participant from the covered dependent spouse,
- The participant becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or
- With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the Policy.

You and Your covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- Your employment with the employer terminates (except if due to the participant's gross misconduct), or

- You are laid off or Your working hours are reduced so as to render him ineligible for coverage as defined in the Policy.

If the You or Your covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

- The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;

- The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within the later of 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage, and before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within 30 days after the final determination is made that the person is no longer totally disabled; and

- The cost for coverage for months one through 18 will be at the rate of 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

- When You or Your dependent fails to make the required contribution (if any) to the plan administrator before the due date or within a grace period of 30 days;

- When the employer or covered dependent first becomes covered by any other group health Policy, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;

- When the Policyholder ceases to maintain any group health Policy; or

- In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled.

A retired Insured and his or her spouse who would otherwise lose health coverage under the Policy after the employer files a Chapter 11 bankruptcy proceeding may continue coverage under the Policy until the death of the insured. Upon the death of the retired covered insured, his covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

If Your or Your dependent first becomes covered under another group health Policy or Medicare while covered hereunder, continuation coverage may continue only during the time that the new group health Policy contains any exclusion or limitation which relates to a pre-existing condition of the insured or dependent. Normal payments for this coverage must be made in order for continuation coverage to remain in effect.

Any other group health Policy will be considered the primary coverage and must always pay benefits before this Policy will consider a claim for benefits. The only exception is that the Policy will remain primary if the COBRA covered person is covered by Medicare by reason of end stage renal disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period, another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

CERTIFICATES OF CREDITABLE COVERAGE

We will issue Certificates of Creditable Coverage for each Insured whose coverage under the Group Policy is terminated. In addition, Certificates shall be issued when requested by an Insured, so long as such request is made within 24 months after cessation of coverage under the Group Policy. Such issuance will occur within a reasonable time.

SECTION 5 – GENERAL PROVISIONS

Grace Period: No Grace Period is allowed for the first premium. A Grace Period of 31 days is allowed for payment of each premium due after the first premium. We will continue Your insurance during the Grace Period. However, if We do not receive Your payment by the end of the Grace Period, Your coverage will terminate retroactive to the premium due date that You failed to pay the required premium. The Grace Period will not continue coverage beyond a date stated in the Termination Provisions.

Notice of Claim: Written notice of claim must be given to Us or Our authorized representative within 90 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Insured.

Claim Forms: We, upon receipt of written notice of claim, will furnish to the Claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the Claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us or Our authorized representative within 90 days after the covered loss. If proof of loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise required or the claim will be denied.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless this Certificate provides for periodic payment.

Payment of Claims: Benefits unpaid at the Insured's death may, at Our option, be paid either to such beneficiary or to the Insured's estate. All other benefits will be payable to the Insured.

If any benefit of this Certificate is payable to an Insured's estate, or to someone who is a minor or otherwise not competent to give a valid release, then We may pay up to $1,000 to any relative by blood, or connection by marriage to the Insured or to the beneficiary who is deemed by Us to be equitably entitled to it. Any such payment made in good faith shall fully discharge Us to the extent of such payment.

Unpaid Premium - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Physical Examination: We, at Our own expense, shall have the right and opportunity to examine an Insured as it may reasonably require while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 Years from the time written proof was required to be given.

[Subrogation: When benefits are paid to or for You or for a Dependent under the terms of the Group Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured or Dependent against any person who might be acknowledge to be liable by a Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by Us of the benefits we have paid for such hospitalization and treatment]

Assignment: You may assign all of Your rights, privileges and benefits under the Group Policy. We are not bound by an assignment until We receive and file a signed copy. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and Federal laws and the terms of the Group Policy.

Medical Claim Payment and Appeals:

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the Insured will be notified of the policy administrator's decision as soon as possible, but no more than 72 hours after the policy administrator receives the claim. If the treating physician classifies a claim as "urgent," the Policy will do so as well.

Extensions:

If information to support a review of an "urgent" claim is incomplete, the following will occur;

- The policy administrator will notify the Insured of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.

- The Insured has 48 hours to provide the missing information or the review of the "urgent" pre-service claim will be closed.

- The policy administrator will make its decision within 48 hours after it receives all necessary information. If a supplemental submission of information is deficient, the time frames begin again.

If an Insured appeals the denial of a pre-service "urgent" claim, the policy administrator must render a review decision as soon as possible, but no more than 72 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Policy:

If a policy administrator has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the policy administrator must notify the Insured of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the Policy has been amended to reduce or end coverage for the treatment, or when the Policy itself terminates.

Extensions of Treatment:

When an Insured requests an extension of an on-going course of treatment beyond that which the policy administrator has approved, the policy administrator must do the following:

- Make a decision about the extension as soon as possible; and

- Notify the Insured of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Managed Care Program

The managed care program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

Pre-Certification Process

Participants or their dependents with the benefit of a managed care program must have every inpatient hospital stay, other than maternity, certified. This is a participant-driven and participant-responsible program. The participant or agent for the participant may call or have the admitting physician or hospital call to certify the stay. Medical, surgical and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within two working days of admission. Maternity admissions for deliveries **do not** require certification. If the newborn baby stays longer in the hospital than the mother, the newborn's continued hospital stay must be certified.

Except in the case of maternity, at the time a medical, surgical or psychiatric inpatient hospital admission is planned, the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre-certification. A penalty per admission as shown in the schedule of benefits will be reflected to the participant if pre-certification requirements are not followed.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

- Plan participant name
- Company name
- Patient's name and age
- Admitting physician's name, address and phone number
- Name of hospital and address

Calls received after hours will be recorded, and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two working days of the emergency admission.

Concurrent Review

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The pre-certification unit staff will monitor the patient's progress throughout the hospital stay to assure discharge is not delayed by inadequate planning and that each day of confinement is medically necessary and appropriate.

The pre-certification staff will contact the hospital utilization review department or the admitting physician for information if additional days are needed beyond those days initially certified. This concurrent review will continue until the patient is discharged.

Inpatient days certified at admissions DO NOT determine the length of inpatient stay. Only the attending physician determines when a patient is to be discharged. The days anticipated at admission may not be needed, or an extension of inpatient days may be required. The physician determines this.

The appeal process is available for a patient's physician when a determination is made that additional days of inpatient care are not medically necessary.

Pre-Service Benefit Claim Review for Coverage

If the policy administrator requires that benefits for a service be predetermined prior to the service being provided, the Insured or the health care provider must submit a request for that pre-service benefit claim review to the policy administrator. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15-day period may be extended for another 15 days if it is necessary because of matters beyond the Policy's control, and if the policy administrator notifies the Insured of those circumstances and the expected date of the decision before the end of the first 15-day period.

- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the Insured 45 days to submit such information.

Normal Post-Service Health Claims

An Insured or health care provider must file a claim with the policy administrator within the time frames set out in the Policy. A claim will be considered to have been filed upon receipt by the policy administrator. The Insured will be notified within 30 days of receipt of a claim by the policy administrator as to the benefits to be paid for that claim.

Extensions:

- The 30-day period may be extended for 15 days if it is necessary due to matters beyond the control of the policy administrator, but the policy administrator will notify the Insured before the end of the 30-day period of those circumstances and the expected date of the decision.

- If more information is necessary to properly process the claim, a notice will be given within the 30-day period that the policy administrator can not meet the 30-day time frame. The notice will describe the missing information and give the Insured at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45-day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the Policy.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the policy administrator, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;

- A reference to any specific Policy provisions on which the determination is based;

- A description of any additional material or information necessary for the Insured to make the claim payable and an explanation of why such material or information is necessary;

- A description of the policy administrator's review procedures and the time limits which are applicable to such procedures, including a statement of the Insured's right to bring a civil action under Section 502(a) of ERISA;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Policy will provide that criterion free of charge upon request; and

- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the policy administrator will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the policy administrator will do the following:

- Allow an Insured 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the policy administrator at the address found in the summary Policy description;

- Allow an Insured the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Provide an Insured, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the Insured's claim for benefits;

- Provide for a review that takes into account all comments, documents, records, and other information submitted by the Insured relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Policy who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual;

- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate policy administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained on behalf of the Policy in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

- Notify the Insured of the policy administrator's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the Insured's appeal, unless the policy administrator determines that special circumstances require an extension of time for processing the appeal.

SECTION 6 - COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does **not** include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Insured is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured is not an Allowable expense.

The following are examples of expenses that are **not** Allowable expenses:

(1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If an Insured is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If an Insured is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If an Insured is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that

provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because an Insured has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the [calendar year] excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When an Insured is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B.(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the [calendar year] is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to [calendar year] commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a [Calendar year] are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If an Insured is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The policy administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. The policy administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give The policy administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, The policy administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The policy administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by The policy administrator is more than it should have paid under this COB provision or for any amount paid out as a part of normal claim payments, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 7 – COVERAGE DESCRIPTIONS

All benefits under the Group Policy are shown in the Schedule of Benefits. The Schedule of Benefits also shows You the annual Plan Maximums, Lifetime Maximums, deductibles and co-payments per Insured for each benefit provided. The benefits are described and governed by the pages attached to and made a part of the Group Policy. For In-Network Eligible Expenses, benefits are payable at the percentage shown in the Schedule of Benefits for each benefit provided. For Out-of-Network Eligible Expenses, benefits are payable at the percentage shown for the Reasonable and Customary charges incurred.

[**INPATIENT CARE**
[If an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for Surgery, Physicians Services, Hospital Inpatient (including room and board, surgeon services and anesthesia), or Other Hospital Charges, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Benefits for Hospital care include Eligible Expenses incurred for Hospital Room and Board Expense, Intensive Care, and Other Hospital Charges for Miscellaneous Hospital Expense including for anesthesia and operating room; laboratory tests and X-rays; oxygen tent; drugs, medicines, dressings and other Durable Medical Equipment and other Medically Necessary and prescribed Hospital Expenses. If while confined as an inpatient an Insured requires the services of a Physician other than a Physician who perform surgery on, or administered anesthesia to, the Insured, We will pay a benefit for Physician Services.]

[We will also pay benefits for Surgical Expenses. Surgical Expense means charges by a Physician for:

a) a Surgical Procedure;
b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
c) usual postoperative treatment.

Surgical Procedure means:

- a cutting procedure;
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- radiotherapy (excluding radioactive isotope therapy)
- cutting operation for removal of a tumor;
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures;
- injection treatment of hemorrhoids and varicose veins;
- an operation by means of laser beam;
- casting;
- removal of a foreign body;
- drainage or aspiration;
- implant;
- catheter placement;
- microsurgery

The maximum benefit payable and co-payment amounts are shown in the Schedule of Benefits.

When an Assistant Surgeon is required to render technical assistance at an operation, the Schedule of Benefits will apply when services are provided by a network provider and if a non-network provider is used, the eligible expense for such services shall be limited to 25% of the reasonable and customary charge for the surgical procedure

If multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s).

Treatment performed outside the Hospital will be paid the same as if performed in a Hospital provided it would have been covered on an inpatient basis.]

[**BENEFITS FOR MATERNITY**

Maternity benefits are available to You and Your Spouse only.

When an Insured is confined to a Hospital as a resident inpatient for childbirth, We will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

a) 48 hours after a non-cesarean delivery; or
b) 96 hours after a cesarean section;

for the mother and the newborn infant(s), unless, at the mother's option, an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. We will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

In the event such earlier discharge occurs, at least one home visit will be available to the mother, and not subject to any deductibles, coinsurance, or co-payment.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) will be conducted within 24 hours following:

a) discharge from the Hospital; or
b) the mother's request; whichever is later.

Benefits include:

a) parent education;
b) assistance and training in breast or bottle feeding; and
c) the performance of any necessary maternal and newborn clinical assessments.]

One ultrasound test will be payable per pregnancy without any additional diagnosis. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary. In addition, for a female Insured over 35 Years of age, charges for the following tests may be considered Eligible Expenses:

- Amniocentesis/AFP Screening;
- Chromosome testing; and
- Fetal stress/non-stress tests.

This Provision is subject to all of the terms of the Group Policy.]

[**OUTPATIENT EXPENSE**
If, by reason of Injury or Sickness, an Insured requires Medically Necessary treatment in a Physician's office, Urgent Care Facility, or licensed ambulatory surgical facility, We will pay the benefits for the treatment and other office services related to such treatment. Treatment of pregnancy is on the same basis as any other Sickness. Benefits include diagnostic X-ray and laboratory examinations, and radiotherapy.

The Covered Percentage, deductible, co-payments and Plan maximums are shown in the Schedule of Benefits.

If the services are in connection with surgery and the Physician is the surgeon who performed the surgery, no benefits are payable under this Provision.

Benefits are payable for Eligible Expenses incurred for the following tests:

- pregnancy tests;
- CBC;
- Hepatitis B Surface Antigen;
- Rubella Screen;
- Syphilis Screen;

- Chlamydia;
- HIV;
- Gonorrhea;
- Toxoplasmosis;
- Blood Typing ABO;
- RH Blood Antibody Screen;
- Urinalysis;
- Urine Bacterial Culture;
- Microbial Nucleic Acid Probe;
- AFP Blood Screening;
- Pap Smear;
- Glucose challenge Test (at 24 weeks gestation); and
- PSA

[**PREVENTIVE CARE**
Benefits are payable for Eligible Expenses incurred by an Insured for the following preventive care. The charges must be incurred while an Insured is insured for these benefits. The annual maximum benefit and co-payment are shown in the Schedule of Benefits. The deductible provision does not apply to these benefits.

Cervical cytology screening and screening mammography

Eligible Expenses include the following:

a) in the case of benefits for cervical cytology screening, annual screening for women (18) eighteen Years of age and older. This coverage shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection, with examining and evaluating the Pap smear.

b) In the case of mammograms:

   1) a baseline mammogram for women at least age 35 but Younger than 40 Years of age.
   2) a mammogram every two Years for asymptomatic women age 40 but Younger than 50 Years of age or more often if recommended by the patient's Physician.
   3) A mammogram every Year for women age 50 or older.

Screening mammography means radiological examination of the breast of asymptomatic women for the early detection of breast cancer, which examination shall include:

a) a cranio-caudal and a medial lateral oblique view of each breast; and
b) a licensed radiologist's interpretation of the results of the procedure. Screening mammography shall not include diagnostic mammography, additional projections required for lesion definition, breast ultrasound, or any breast interventional procedure. Screening mammography shall be performed by a mammogram supplier who meets the standards of the Federal Mammography Quality Standards Act of 1992.

Routine Annual Examination for Adult Insured: Benefits are also payable for one annual check-up to a Physician per Insured for a wellness visit. Benefits include all related charges up to the amount shown in the benefit schedule.

Routine Well Child Care Benefits: Benefits are payable for child wellness services which are rendered during a periodic review are covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one visit. Covered services include: medical history; measurement of height, weight and head circumference; testing of blood pressure; sensory screening including vision and hearing; hereditary and metabolic screening in accordance with state law; developmental/behavioral assessment; immunizations consistent with prevailing

American Academy of Pediatric Committee statements; tuberculin test; hematocrit or hemoglobin; urinalysis; and anticipatory guidance.]

[EMERGENCY ROOM SERVICES
Subject to any co-payment, if an Insured incurs Eligible Expenses in a Hospital Emergency Room for treatment of a medical emergency due to Injury or Sickness, we will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers. The co-payment is waived if the Insured is admitted to the Hospital as an inpatient.]

[SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are payable if an Insured incurs Eligible Expenses for treatment of a medical emergency due to an Accident, we will pay the benefits shown on the Schedule of Benefits on the percentages shown for In-Network or Out-of-Network Providers.]

[CARDIAC, OCCUPATIONAL, PHYSICAL, PULMONARY, SPEECH THERAPIES, AND CHIROPRACTIC CARE
Subject to any co-payment and deductible requirements, if an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for cardiac, occupational, physical, pulmonary, and speech therapies and chiropractic care, we will pay the benefits shown in the Schedule of Benefits. The treatment must be for rehabilitation, must be Medically Necessary, and be prescribed by a Physician.

These services/therapies each has a benefit maximum of 20 visits per Insured, per [plan year] whether provided on an out-patient or inpatient basis. The benefit maximum renews each [plan year].

Each treatment date counts as one visit for each service provided, even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides You with physical therapy and occupational therapy on the same day, the services are counted as one visit for physical therapy and one visit for occupational therapy. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied toward the maximum benefit limit.

Physical therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a neuromuscular condition that can be significantly improved within a 6-month period of time.

We pay for physical therapy performed by:

- A doctor of medicine, osteopathy or podiatry
- A dentist for the oral-facial complex
- An optometrist for services for which they are licensed
- A certified nurse practitioner
- A licensed physical therapist under the direction of a Physician
- Other individuals under the direct supervision of a licensed physical therapist, MD or DO or
- A licensed independent physical therapist
-

Services do not include:

- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy
- Physical therapy performed by a chiropractor except mechanical traction

Speech and language pathology services must be:

- Prescribed by a Physician licensed to prescribe them
- Given for a condition that can be significantly improved within 6-months
- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist.

The clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

Occupational Therapy must be:

- Prescribed by a Physician licensed to prescribe it and
- Given for a condition that can be significantly improved within 6 months and
- Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of in which he or she practices). The occupational therapy assistant must be under the direct supervision of a registered occupational therapist, who cosigns all assessments and patients' progress notes.

Services do **not** include:

- Occupational therapy examinations or evaluations without an occupational therapy treatment plan and where there is no progress
- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- Recreational therapy

Cardiac Rehabilitation Therapy includes intensive monitoring (EKGs) and/or supervision during exercise in a Physician-directed clinic (one in which a Physician is on-site).

Chiropractic services include manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, applications of heat or cold by a Physician or chiropractor.

Pulmonary Therapy includes respiratory therapies prescribed by a Physician as Medically Necessary treating Insureds with chronic breathing problems that include:

- Asthma
- Emphysema
- COPD (Chronic Obstructive Pulmonary Disease)
- Sarcoidosis
- Cystic Fibrosis
- Pulmonary Fibrosis
- Chronic Bronchitis
- Interstitial lung Disease
- Pre and post lung volume reduction surgery
- Bronchiectasis
- Other cardiopulmonary disorders]

[**TRANSPLANT RELATED EXPENSES**
Subject to any deductible payment, if an Insured incurs Transplant related Eligible Expenses, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Allogenic Transplants
We will pay the Reasonable and Customary expenses incurred for allogenic transplants as follows:

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is: a) A first degree relative and matches at least four of the six important HLA genetic markers with the patient; or b) Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This Provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.) Harvesting and storage will be covered if it is not covered by the donor's insurance. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants
We will pay the Reasonable and Customary expenses incurred for autologous transplants as follows:

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of "Tandem Transplant" in the Definitions Section.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Aplastic anemia
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency Disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)

- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Megakaryocytic thrombocytopenia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucolipidoses (e.g., Gaucher's Disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's Disease (high risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

NOTE: In addition to the conditions listed above, We will pay for services related to, or for high dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage to antineoplastic drugs when a state law requires that these drugs, and the reasonable cost of their administration, be covered.

We do **not** pay the following for bone marrow transplants:

- Services that are not Medically Necessary
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- An allogeneic tandem transplant
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

Specified human Organ Transplants
When performed in a designated facility, We pay for transplantation of the following human organs:

Combined small intestine-liver
Heart
Heart-lung(s)
Liver
Lobar lung
Lung(s)
Pancreas
Partial liver
Simultaneous pancreas-kidney
Small intestine (small bowel)

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided while coverage is in force under the Group Policy and such services must begin five days before and end one Year after the organ transplant to be covered.

When directly related to the transplant, We pay for:

Facility and professional services
Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed.

Medically Necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during a benefit period and is the direct result of the organ transplant surgery.

We do **not** pay for the following for specified human organ transplants:

- Services that are not covered benefits under the Group Policy
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
- Anti-rejection drugs that do not have a Food and Drug Administration marketing approval
- Transplant surgery and related services that are not performed in a designated facility. You must pay for the transplant surgery and related services You receive in a non-designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and Hospitalization
- Services prior to Your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under the Group Policy
- Experimental transplant procedures. See the definition of experimental treatment

SECTION 8- EXCLUSIONS AND LIMITATIONS

The following are not Eligible Expenses and not covered under the Group Policy:

1. [Injury arising out of or in the course of employment, or activity for wage or profit, or which is compensable under Workers' Compensation or Occupational Disease Act or Law.]
2. [Experimental or investigational services, drugs, or supplies except to the extent required by law;]
3. [Educational testing or training related to learning disabilities or developmental delays;]
4. [Custodial care or personal items;]
5. [Any expense incurred before the Effective Date of an insured's insurance under the Policy or after the termination date of an Insured's insurance.]
6. [Eye surgery to correct refractive errors;]

7. [Therapy, supplies, or counseling for sexual dysfunctions]
8. [Performance, or lifestyle enhancement drugs or supplies]
9. [Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered]
10. [Routine physical, vision, or hearing exams, immunizations, or other preventive services or supplies, except to the extent that coverage is specifically provided under the Group Policy;]
11. [Dental care except for Injury to sound natural teeth;]
12. [Elective surgery;]
13. [Cosmetic Surgery other than reconstructive Surgery incidental to or following surgery resulting from trauma, infection, or other Diseases of the involved part; or reconstructive surgery because of a congenital Disease or anomaly;or according to the requirements of the Women's Health and Cancer Rights Act]
14. [Speech therapy except as otherwise specifically covered under the Group Policy;]
15. [Inpatient or outpatient treatment of alcoholism, drug abuse, and mental illnesses; except where required by law]
16. [Private duty nursing;]
17. [An Injury sustained while the Insured is legally intoxicated or under the influence of alcohol as defined by the jurisdiction where the Accident occurred;]
18. [Charges made to treat a Sickness or Injury sustained while flying as a pilot or crew member;]
19. [Voluntary sterilization procedure or the reversal of a sterilization procedure;]
20. [Weight control services including surgical procedures, medical treatments, weight control/loss programs; food supplements or exercise programs or equipment; and]
21. [Intentionally self inflicted injury or action unless the result of a medical condition]
22. [War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.]
23. [Services and supplies not medically necessary, recommended or approved for the diagnosis, care, or treatment of the disease or injury involved by the treating physician.]
24. [Charges made for: manipulative (adjustive) treatment; or treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.]
25. [Prescription drugs and medicines prescribed by a physician [on an outpatient basis]]
26. [Charges in excess of the Recognized Charge, based on the 90th percentile of the Medicode Medical Data Research Tables.]
27. [Charges for any treatment received while in a skilled nursing facility will not be covered.]
28. [Charges for any treatment for Home Health Care, except as covered under maternity.]
29. [Transportation charges, including ambulatory services.]
30. [Charges for biofeedback.]
31. [Any Treatment received under hospice care.]
32. [Elective or voluntary abortions, except in the case of rape, incest or congenital deformities.]
33. [Charges for Prosthetics and/or orthotics.]
34. [Charges for Temporomandibular Joint Disorder (TMJ).]

PRE-EXISTING CONDITIONS: Expenses incurred for treatment of Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy.

Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy. This limitation will **not** apply if:

a) The individual seeking coverage under the Group Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage Credit will be given for the time the individual was covered under prior Creditable Coverage that is not separated by a break in coverage of 63 days or more; and
b) The individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

Pre-existing Conditions does **not** apply to:

a) a newborn Dependent child; or
b) a child adopted by the Insured or placed with the Insured for adoption, if adoption or placement for adoption occurs while covered under the Group Policy.

CREDIT FOR PRIOR COVERAGE: An Insured whose coverage under prior Creditable Coverage ended no more than 63 days before the Insured's Effective Date under the Group Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break. The Insured must provide proof of prior Creditable Coverage.

Creditable Coverage means coverage under any of the following:

a) Any individual or Group Policy, contract, or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee Plan, or any other entity, and that arranges or provides medical, Hospital and surgical coverage not designed to supplement other private or governmental plans;
b) The Federal Medicare Program pursuant to Title XVIII of the Social Security Act;
c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
d) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);
e) a medical care program of the Indian Health Service or of a tribal organization;
f) a state health benefits risk pool;
g) a health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) Federal Employees Health Benefits Program (FEHBP);
h) a public health plan as defined under section 5(e) of the Peace Corps Act (22 U.S.C.A. Section 2504(e)); or
i) any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the Federal Public Health Services Act (42 U.S.C. Section 300gg(c)).

Creditable Coverage includes continuation or Conversion coverage but does **not** include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

ENROLLMENT FORM

Please Mail To: Post Office Box 2086
Fort Mill, South Carolina 29716-2086

(866)-543-0896

FOR OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Mid Med		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)	Social Security Number	Gender	Date of Birth

Street Address	City	State	Zip

Employer/Group #	Job Class	Location	Date of Hire

Hours Worked	Daytime Phone No.
Are you actively at work? ☐ YES ☐ NO	

ENROLLMENT INFORMATION

☐ **New Enrollment** ☐ **Change** **Special Circumstances:** Date: _____ Reason: _____	**Plan Selection:** ☐ Basic ☐ Enhanced ☐ Other:_____
Coverage Level (choose one): ☐ Employee Only ☐ Employee Plus One ☐ Employee and Family	
Monthly Premium: $ _____ **Section 125:** ☐ Yes ☐ No	

DEPENDENT INFORMATION

Please complete for all covered dependents.

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

Relationship	First Name	M.I.	Last Name	S.S.#	Gender	Date of Birth	Full Time Student

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury that was diagnosed by consultation, advice or treatment within 6 months prior to the Effective Date of coverage for the Covered Person.

This is Important - Please Read
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: _____

Date of Signature: _____

- **YES, I DO WANT THIS COVERAGE**

• I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.

• All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.

• I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.

• Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

• Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).

• Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty or insurance fraud.

• I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: $ _____

[Member/Employee] Acceptance: _____

Date of Signature:_____

- **No, I decline coverage for myself and/or spouse**

☐ I decline coverage because I am covered under another group policy of medical insurance.

☐ I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.

☐ I decline coverage but I do not have another group policy of medical insurance.

(Member/Employee) Declination: _____

Date of signature: _____

Agent Signature: _____ Date of Signature: _____

APPLICATION FOR GROUP INSURANCE

Application is hereby made to:

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street Columbia, South Carolina 29205
(800) 308-6457

Name of Applicant:_____
[Policyholder]

Address: _____
[Policyholder Address]

To be effective in the state of [Situs State] governed by the laws thereof.

Total Number of Eligible Employees/Members: _____
[Number of Eligible Employees/ Members]

□ Contributory □ Non-Contributory

Eligible Classes as defined by the Policyholder:

SCHEDULE OF BENEFITS

Plan of Insurance	**In-Network**	**Out-of-Network**
Lifetime Plan Maximum	[$5,000 - unlimited] per Insured	
Annual Plan Maximum	[$5,000 - unlimited] per Insured	
[Calendar Year] Deductible (Individual/Family)	[$0-$100,000 / $0 - $300,000]	[$0-$100,000 / $0 - $300,000]

[Calendar Year] Deductibles apply to every expense listed below, unless otherwise noted.
Co-payments are not applied to the [Calendar Year] Deductible.
Any paid deductible is used to satisfy both in-network and out-of network requirements

In-Patient Care		
[Surgery-Inpatient, Physicians Services	[Surgery In-patient MD 20% - 100%]	[Surgery In-patient MD 20% - 100%]
[Hospital Inpatient (Facility)	[Hospital In-patient (Facility) 20%-100%]	[Hospital In-patient (Facility) 20%-100%]
[Other Hospital Charges (Including hospital based Professional charges) See Note (A)	[20%-100%]	[20%-100%]
[Physician Services (Inpatient visits)	[20%-100%]	[20%-100%]
[Maternity Care (You and covered Spouse only)	[20%-100%]	[20%-100%]
Out-patient Care -See Note (B)		
[Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	[$0-$150] Co-pay Then [20% - 100%]	[20% - 100%]
[Other Office Services provided during the Office Visit	[20% - 100%] No Calendar Year Deductible	[20% - 100%]
[Urgent Care Facility	[20% - 100%]	[20% - 100%]
[Surgery, Out-patient	[20% - 100%]	[20% - 100%]
[Maternity Care (You and covered Spouse only)	[20% - 100%]	[20% - 100%]
[Supplemental Accidental Benefit	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]]

[Emergency Room (if not admitted in-patient)	[20% - 100%] after [$0-$1000] Co-pay	[20% - 100%] after [$0-$1000] Co-pay]
[Cardiac, Occupational, Physical, Pulmonary & Speech Therapies and Chiropractic See Note (C)	[20% - 100%]	[20% - 100%]
[Transplant-Related Expenses	[0% - 100%]	[0% - 100%]
[Routine Physical Exams, Pap Smears, Mammograms; PSA's See Note (D)	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit]	[20% - 100%]] No Calendar Year Deductible [$25-$750] Calendar Year Benefit]]
[Routine Well Child Care	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit	[20% - 100%] No Calendar Deductible] [$25-$750] Calendar Year Benefit]]
Others		
Mental Health	Not covered unless required by law	Not covered unless required by law
Substance Abuse Care	Not covered unless required by law	Not covered unless required by law

NOTES: (A): Other Inpatient Hospital Charges are subject to [$5,000-unlimited] Annual Maximum per Insured.
(B): Outpatient Care is subject to [$5,000-unlimited] Annual Maximum per Insured.
(C): Subject to [5-60] visits per category per [Calendar Year] per Insured.
(D): Routine Physical Exams include all related charges up to [$25-unlimited] Calendar Benefit.

This Group Application is attached to and made a part of Group Policy_____.

The policy is effective on [Date].

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of the crime of insurance fraud and may be subject to fines and confinement to prison.

Date: _____ By: _____
Applicant

Agent: _____ _____
Signature of Officer

_____
Official Position

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Insured Persons who are **residents** of the State of Arkansas on the Certificate Date and on the date the claim is incurred.

RENEWABILITY

This Policy/Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew this Certificate because of any change in a Covered Person's health or physical condition. We may refuse to renew the coverage of a covered employee or dependent if:

(a) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(b) the covered employee or dependent has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the health benefit plan, including claims for benefits under the health benefit plan;

(c) We cease to offer health benefit plan coverage in the employer market and offer the option to purchase any other benefit plan; or

Medicare eligibility or entitlement is not a basis for non-renewal or termination of a health benefit plan issued to an employee. However, benefits may be subject to the Coordination of Benefits Provision.

If this Certificate is terminated in accordance with the above condition, a Covered Person's coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will not send written notice of any termination for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

In Section 7, the following Mandated Benefits will be included

I. BENEFITS FOR DIABETES COVERAGE

Benefits will be paid the same as any other Sickness for Diabetes. Included is medical coverage for medically necessary equipment, supplies and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a licensed physician.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

II. BENEFITS FOR SELF-MANAGEMENT TRAINING COVERAGE

Benefits will be paid the same as any other Sickness for Diabetes Self-Management Training. One diabetes self-management training is covered per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.

In addition, additional diabetes self-management training is offered in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Diabetes self-management training shall be provided only upon prescription by a physician licensed.

Nothing in this provision shall be construed to prohibit us from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

III. [BENEFITS FOR CHILDRENS PREVENTIVE HEALTH CARE

Benefits will be paid the same as any other Sickness for Children's Preventive Health Care. Minimum basic benefits offered shall provide basic levels of primary, preventive, and hospital care, including the following:

1. Fifteen (15) days of inpatient hospitalization coverage per policy year;

2. a. Prenatal care, including:
   i. One (1) prenatal office visit per month during the first two (2) trimesters of pregnancy,
   i. Two (2) office visits per month during the seventh and eighth months of pregnancy, and
   iii. One (1) office visit per week during the ninth month until term.

   b. Coverage for each office visit shall include:
   i. Necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member; and
   ii. Such prenatal counseling as the physician deems appropriate;

3. Obstetrical care, including physicians' services, delivery room, and other medically necessary hospital services;

4. Coverage for children's preventive health care services are offered on a periodic basis from birth through age six (6) including thirteen (13) visits at approximately the following age intervals: birth, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years.

This benefit provides that children's preventive health care services which are rendered during a periodic review shall:

1. Only be covered to the extent that these services are provided by or under supervision of a single physician during the course of one (1) visit; and
2. Be reimbursed at levels established by the Insurance Commissioner which shall not exceed those established for the same services under the Medicaid program in the State of Arkansas.

5. A basic level of primary and preventive care, including two (2) office visits per calendar year for covered services rendered by a provider licensed to provide the services rendered;

6. Annual, lifetime, or other benefit limits shall be not less than one hundred thousand dollars ($100,000) as an annual benefit, and two hundred fifty thousand dollars ($250,000) as a lifetime benefit;

7. a. Newborn infant children are covered from the moment of birth and for adopted minors from the date of the interlocutory decree of adoption;

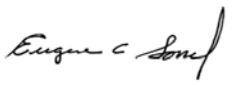
b. We require that the insured give notice of any newborn children within ninety (90) days following the birth of the newborn infant and of any adopted child within sixty (60) days of the date the insured has filed a petition to adopt. The coverage of newborn children or adopted children shall not be less than the same as is provided for other members of the insured's family.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

This endorsement takes effect and expires concurrently with the policy or certificate to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

There are no other changes to the certificate.

In Witness Whereof, We have caused this Endorsement to be signed by



President

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice — Approved-Closed — 01/15/2009

Comments:

Attachment:

CAIC Cert of Compliance.pdf

Review Status:

Bypassed -Name: Application — Approved-Closed — 01/15/2009

Bypass Reason: We are filing an application with this product.

Comments:

Review Status:

Satisfied -Name: Readability Certification — Approved-Closed — 01/15/2009

Comments:

Attachment:

CAIC Readability Certificate.pdf

Review Status:

Satisfied -Name: Submission Letter — Approved-Closed — 01/15/2009

Comments:

Attachment:

Submission Letter- Arkansas.pdf

Review Status:

Satisfied -Name: John Doe Applications — Approved-Closed — 01/15/2009

Comments:

Attachments:

CAI1010 Master App-Final John Doe.pdf

CAI1011A Enrollment App 7.9.08-Final John Doe.pdf

CAI1011 Enrollment App 7.9.08-Final John Doe.pdf

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Satisfied -Name: Response Letter

Review Status: Approved-Closed 01/15/2009

Comments:

Attachment:

ReSubmission Letter- Arkansas 11-13-08.pdf

Satisfied -Name: Certification for Bulletin 9-85

Review Status: Approved-Closed 01/15/2009

Comments:

Attachment:

CAIC Certification for Bulletin 9-85.pdf

Satisfied -Name: Resubmission Letter

Review Status: Approved-Closed 01/15/2009

Comments:

Attachment:

Resubmission Letter - Arkansas 1-15-09.pdf

Continental American
INSURANCE COMPANY

2801 Devine Street, Columbia, South Carolina 29205

CERTIFICATION OF COMPLIANCE

I have reviewed or supervised the review of the form contained in the filing and hereby certify that to the best of my knowledge and belief they are in compliance with the applicable statues, regulations and bulletins of the State of Arkansas. I further certify that they will be revised and/or discontinued in the event of future changes in the statues, regulations, or bulletins which would prohibit the use of such forms.

James J. Hennessy
cn=James J. Hennessy, c=US, o=Continental American Insurance Company, email=JHennessy@caicworksite.com
2008.10.17 09:38:29 -04'00'

James J. Hennessy, AIRC, ACP,CCP
Vice President, Compliance CAIC

October 17, 2008
Date

Continental American
INSURANCE COMPANY

READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following form has the following combined policy, certificate, rider and application readability score as calculated by the Flesch Reading Ease Test**: 50.**

Form

CAI1000AAR	Association Group Master Policy
CAI1001AAR	Association Group Certificate
CAI1011A	Association Enrollment Application
CAI1000AR	Employer Group Master Policy
CAI1001AR	Employer Group Certificate
CAI1011	Employer Enrollment Application
CAI1038	Endorsement
CAI1010	Master Application

James J. Hennessy
cn=James J. Hennessy, c=US, o=Continental American Insurance Company, email=JHennessy@caicworksite.com
2008.10.17 09:39:37 -04'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance, CAIC

October 17, 2008
Date

2801 Devine Street, Columbia, South Carolina 29205

October 17, 2008

Ms. Rosalind Minor
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Continental American Insurance Company
FEIN 57-0514130 NAIC 71730

Group Hospital/Medical Insurance Policy
Forms:

CAI1000AAR- Association Group Master Policy
CAI1001AAR- Association Group Certificate
CAI1011A- Association Enrollment Application
CAI1000AR- Employer Group Master Policy
CAI1001AR- Employer Group Certificate
CAI1011- Employer Enrollment Application
CAI1038AR- Endorsement
CAI1010-Master Application

Dear Ms. Minor,

The above captioned forms are being filed for your review and subsequent approval. This is a new filing, and will not replace any forms now on file with your department. This is a hospital/medical /surgical expense insurance policy. This plan can be offered to an association and an employer. This coverage is a voluntary employee membership benefit that is guarantee issued during the enrollment period and individually underwritten outside specified enrollment periods.

The product provides limited hospital/medical/surgical expense insurance benefits and is available to eligible persons and their dependents.

Please note that the Endorsement (CAI1038AR) and the Master Application (CAI1010) can be used for both association and employer groups.

We appreciate your review and approval of the form filing. Thank you for your consideration in this matter. Please contact Ashley Gibson at 888-730-2244 ext: 4362 or at CompanyCompliance@caicworksite.com if you need any additional information.

Sincerely,

James J. Hennessy
cn=James J. Hennessy, c=US,
o=Continental American Insurance Company,
email=JHennessy@caicworksite.com
2008.10.17 10:52:29 -04'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance, CAIC
/ahg

APPLICATION FOR GROUP INSURANCE

Application is hereby made to:

CONTINENTAL AMERICAN INSURANCE COMPANY

2801 Devine Street Columbia, South Carolina 29205
(800) 308-6457

Name of Applicant: ABC Company
[Policyholder]

Address: 124 Main Street, Columbia, Arkansas 29111
[Policyholder Address]

To be effective in the state of [Arkansas] governed by the laws thereof.

Total Number of Eligible Employees/Members: 25
[Number of Eligible Employees/ Members]

☐ Contributory ☒ Non-Contributory

Eligible Classes as defined by the Policyholder:

SCHEDULE OF BENEFITS

Plan of Insurance	**In-Network**	**Out-of-Network**
Lifetime Plan Maximum	[$5,000 - unlimited] per Insured	
Annual Plan Maximum	[$5,000 - unlimited] per Insured	
[Calendar Year] Deductible (Individual/Family)	[$0-$100,000 / $0 - $300,000]	[$0-$100,000 / $0 - $300,000]

[Calendar Year] Deductibles apply to every expense listed below, unless otherwise noted.
Co-payments are not applied to the [Calendar Year] Deductible.
Any paid deductible is used to satisfy both in-network and out-of network requirements

In-Patient Care		
[Surgery-Inpatient, Physicians Services	[Surgery In-patient MD 20% - 100%]	[Surgery In-patient MD 20% - 100%]
[Hospital Inpatient (Facility)	[Hospital In-patient (Facility) 20%-100%]	[Hospital In-patient (Facility) 20%-100%]
[Other Hospital Charges (Including hospital based Professional charges) See Note (A)	[20%-100%]	[20%-100%]
[Physician Services (Inpatient visits)	[20%-100%]	[20%-100%]
[Maternity Care (You and covered Spouse only)	[20%-100%]	[20%-100%]
Out-patient Care -See Note (B)		
[Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	[$0-$150] Co-pay Then [20% - 100%]	[20% - 100%]
[Other Office Services provided during the Office Visit	[20% - 100%] No Calendar Year Deductible	[20% - 100%]

[Urgent Care Facility	[20% - 100%]	[20% - 100%]
[Surgery, Out-patient	[20% - 100%]	[20% - 100%]
[Maternity Care (You and covered Spouse only)	[20% - 100%]	[20% - 100%]
[Supplemental Accidental Benefit	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]]
[Emergency Room (if not admitted in-patient)	[20% - 100%] after [$0-$1000] Co-pay	[20% - 100%] after [$0-$1000] Co-pay]
[Cardiac, Occupational, Physical, Pulmonary & Speech Therapies and Chiropractic See Note (C)	[20% - 100%]	[20% - 100%]
[Transplant-Related Expenses	[0% - 100%]	[0% - 100%]
[Routine Physical Exams, Pap Smears, Mammograms; PSA's See Note (D)	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit]	[20% - 100%]] No Calendar Year Deductible [$25-$750] Calendar Year Benefit]]
[Routine Well Child Care	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit	[20% - 100%] No Calendar Deductible] [$25-$750] Calendar Year Benefit]]
Others		
Mental Health	Not covered unless required by law	Not covered unless required by law
Substance Abuse Care	Not covered unless required by law	Not covered unless required by law

NOTES: (A): Other Inpatient Hospital Charges are subject to [$5,000-unlimited] Annual Maximum per Insured.
(B): Outpatient Care is subject to [$5,000-unlimited] Annual Maximum per Insured.
(C): Subject to [5-60] visits per category per [Calendar Year] per Insured.
(D): Routine Physical Exams include all related charges up to [$25-unlimited] Calendar Benefit.

This Group Application is attached to and made a part of Group Policy CAI1000AR .

The policy is effective on [January 1, 2009].

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of the crime of insurance fraud and may be subject to fines and confinement to prison.

Date: October 17, 2008 By: John Smith
Applicant

Agent: Ashley Agent *John Smith*
Signature of Officer

CEO
Official Position

ENROLLMENT FORM

Please Mail To: Post Office Box 2086
Fort Mill, South Carolina 29716-2086

(866)-543-0896

FOR OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Mid Med		
Endorsement:		
EFFECTIVE DATE:		

[Member] Name/Owner (First, MI, Last)	Social Security Number	Gender	Date of Birth
John M. Doe	111-11-1111	Male	1-1-1981

Street Address	City	State	Zip
12 Main Street	Irmo	AR	29111

[Policyholder]/Group #	Job Class	Location	Date of Hire
1234	A	Irmo, AR	1-1-01

Hours Worked	Daytime Phone No.
40 per week	(803) 359-9984

Are you actively at work? **x** YES ☐ NO

ENROLLMENT INFORMATION

x New Enrollment ☐ Change **Special Circumstances:** Date: _____ Reason: _____	**Plan Selection:** ☐ Basic x Enhanced ☐ Other: _____
Coverage Level (choose one): x [Member] Only ☐ [Member] Plus One ☐ [Member] and Family	
Monthly Premium: $ xx.xx **Section 125:** ☐ Yes **x** No	

DEPENDENT INFORMATION

Please complete for all covered dependents.

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

Relationship	First Name	M.I.	Last Name	S.S.#	Gender	Date of Birth	Full Time Student

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury which was diagnosed or treated by a Doctor prior to the Covered Person's Effective Date of coverage for the Covered Person with consultation, advice or treatment by a Doctor within 6 months prior to the Effective Date of coverage for the Covered Person.

This is Important - Please Read
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: John M. Doe

Date of Signature: October 17, 2008

- **YES, I DO WANT THIS COVERAGE**

• I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.

• All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.

• I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.

• Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

• Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).

• Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty or insurance fraud.

• I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: $ xx.xx

[Member] Acceptance: John M. Doe

Date of Signature: October 17, 2008

- **No, I decline coverage for myself and/or spouse**

☐ I decline coverage because I am covered under another group policy of medical insurance.

☐ I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.

☐ I decline coverage but I do not have another group policy of medical insurance.

(Member) Declination: _____

Date of signature: _____

Agent Signature: Ashley Agent Date of Signature: October 17, 2008

ENROLLMENT FORM

Please Mail To: Post Office Box 2086
Fort Mill, South Carolina 29716-2086

(866)-543-0896

FOR OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Mid Med		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)	Social Security Number	Gender	Date of Birth
John M. Doe	111-11-1111	Male	1-1-1981

Street Address	City	State	Zip
12 Main Street	Lexington	OR	29111

Employer/Group #	Job Class	Location	Date of Hire
1234	A	Irmo, OR	1-1-2001

Hours Worked	Daytime Phone No.
40 per week	(803) 359-1111

Are you actively at work? **x** YES ☐ NO

ENROLLMENT INFORMATION

x New Enrollment ☐ Change **Special Circumstances:** Date: _____ Reason: _____	**Plan Selection:** ☐ Basic x Enhanced ☐ Other: _____
Coverage Level (choose one): x Employee Only ☐ Employee Plus One ☐ Employee and Family	
Monthly Premium: $ xx.xx **Section 125:** ☐ Yes x No	

DEPENDENT INFORMATION

Please complete for all covered dependents.

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

Relationship	First Name	M.I.	Last Name	S.S.#	Gender	Date of Birth	Full Time Student

I understand that Continental American Insurance Company will not pay benefits for any medical condition or illness due to a Pre-existing Condition for up to (12) months. The (12) month period will be reduced based on prior creditable coverage as shown by a Certificate of Prior Creditable Coverage which I must provide. A Pre-existing Condition is any disease, illness, Sickness or Injury that was diagnosed by consultation, advice or treatment within 6 months prior to the Effective Date of coverage for the Covered Person.

This is Important - Please Read
This Election for Coverage Cannot Be Processed Unless The Form Is Signed and Dated.

A new Enrollment Form must be completed for any change such as name change, birth of a child, marriage, adoption of a child, addition of a covered dependent. The new form must be dated, signed and submitted electronically or by email to the Administrator.

I understand that Mid Medical Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on the plan selected. These benefits are provided under a group insurance policy underwritten by Continental American Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a limited medical plan that provides for limitations to the coverage and a reduced annual and life time limit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

I acknowledge that I have read the above Notice: John M. Doe

Date of Signature: October 15, 2008

- **YES, I DO WANT THIS COVERAGE**

• I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Continental American Insurance Company.

• All information submitted by me on this form at Continental American Insurance Company's request, to the best of my knowledge and belief, is true and complete.

• I am applying for coverage with Continental American Insurance Company. I authorize any physician, medical practitioner, hospital, clinic or medical-related facility or insurance company having information available as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition and/or treatment of me or my insured dependents to give/allow the Insurance Company or their legal representatives any and all such information.

• Any information obtained will not be released by the Insurance Company to any person or organization except to persons or organizations performing business or legal services in connection with my application or a claim for benefits or as may be otherwise lawfully required or as I may further authorize. I understand that this information obtained by the Insurance Company will be used to determine appropriate and accurate medical charges.

• Furthermore, I hereby authorize any physician or practitioner, hospital, or other organization, institution or person, that has any medical records or knowledge of me or my family, to give to Continental American Insurance Company such information (photocopy of this authorization shall be valid as the original).

• Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty or insurance fraud.

• I also understand that my coverage and that of my dependents, if any, will be subject to the pre-existing condition limitation and exclusion provision specified in the Master Policy and that this provision has been fully explained to me.

Total Monthly Insurance Amount: $ xx.xx

[Member/Employee] Acceptance: John M. Doe

Date of Signature: October 15, 2008

- **No, I decline coverage for myself and/or spouse**

☐ I decline coverage because I am covered under another group policy of medical insurance.

☐ I decline coverage fro my spouse because he/she is covered under another group policy of medical insurance.

☐ I decline coverage but I do not have another group policy of medical insurance.

(Member/Employee) Declination: _____

Date of signature: _____

Agent Signature: Ashley Agent Date of Signature: October 15, 2008

2801 Devine Street, Columbia, South Carolina 29205

November 13, 2008

Ms. Rosalind Minor
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Continental American Insurance Company
FEIN 57-0514130 NAIC 71730

Group Hospital/Medical Insurance Policy
Forms:

CAI1000AAR- Association Group Master Policy
CAI1001AAR- Association Group Certificate
CAI1011A- Association Enrollment Application
CAI1000AR- Employer Group Master Policy
CAI1001AR- Employer Group Certificate
CAI1011- Employer Enrollment Application
CAI1038AR- Endorsement
CAI1010-Master Application

Dear Ms. Minor,

Per objection letter dated October 17, 2008, we have made the following revisions:

1. We removed the following wording from both employer and association certificates: “within 31 days after coverage would otherwise terminate” and “but not more often than once a Year”.
2. We have attached a certification for Bulletin 9-85 to this response to certify that there will be no more than a 25% differential in the payment of benefits to a PPO and Non-PPO.

We appreciate your review and approval of the form filing. Thank you for your consideration in this matter. Please contact me at 888-730-2244 ext: 4362 or at CompanyCompliance@caicworksite.com if you need any additional information.

Sincerely,

Ashley Gibson
cn=Ashley Gibson, c=US, o=Continental American Insurance Company, email=agibson@caicworksite.com
2008.11.13 14:24:04 -05'00'

Ashley Gibson
Compliance Analyst

Continental American
INSURANCE COMPANY

CERTIFICATION

I, James J. Hennessy, hereby certify that benefits payable a PPO and Non-PPO will comply with Bulletin 9-85 and that there will be no more than a 25% differential in the payment of benefits to a PPO and Non-PPO.

James J. Hennessy
cn=James J. Hennessy, c=US, o=Continental American Insurance Company, email=JHennessy@caicworksite.com
2008.11.13 14:21:48 -05'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance, CAIC

November 13, 2008
Date

2801 Devine Street, Columbia, South Carolina 29205

January 15, 2009

Ms. Rosalind Minor
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Continental American Insurance Company
FEIN 57-0514130 NAIC 71730

Group Hospital/Medical Insurance Policy
Forms:

CAI1000GRAR- Employer Group Master Policy
CAI1001AR- Employer Group Certificate
CAI1011- Employer Enrollment Application
CAI1038AR- Endorsement
CAI1010-Master Application

Dear Ms. Minor,

Thank you so much for reopening this filing! We have made changes in the master policy under the two provisions for "Cancelation" and "Renewability". We have also revised the language in the "Renewability" provision under the endorsement because there was association language referenced when this endorsement will only be used for employer groups.

To confirm our conversation, we will submit association Group Hospital/Medical Insurance Policy forms on a case by case basis for association groups and these forms will only be used for employer groups.

We appreciate your review and approval of the form filing. Thank you for your help today! Please contact me at 888-730-2244 ext: 4362 or at CompanyCompliance@caicworksite.com if you need any additional information.

Sincerely,

Ashley Gibson

Ashley Gibson
cn=Ashley Gibson, c=US,
o=Continental American Insurance Company,
email=agibson@caicworksite.com
2009.01.15 11:26:02 -05'00'

Ashley Gibson
Compliance Analyst

SERFF Tracking Number:	*CAIC-125862108*	*State:*	*Arkansas*
Filing Company:	*Continental American Insurance Company*	*State Tracking Number:*	*40584*
Company Tracking Number:	*28*		
TOI:	*H15G Group Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15G.002 Large Group Only*
Product Name:	*MID MED Arkansas*		
Project Name/Number:	*Mid Med/28*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Employer Policy	10/17/2008	CAI1000AR Master Policy - Arkansas.pdf
No original date	Form	Endorsement	10/17/2008	CAI1038AR Endorsement AR.pdf
No original date	Form	Association Certificate	10/17/2008	CAI1001AAR Certificate Arkansas.pdf
No original date	Form	Employer Certificate	10/17/2008	CAI1001AR Certificate - Arkansas.pdf

2802 Devine Street, Columbia, SC 29205
800-433-3036

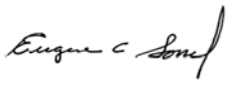
Group Hospital-Medical-Surgical Expense Policy

In return for the payment of premium expressed in the Schedule of Benefits, Continental American Insurance Company, a stock company herein called We, Us, or Our, agrees with the Policyholder to pay the benefits of this Group Policy to the persons insured hereunder, subject to the terms and conditions that follow. This Group Policy is executed as of the Policy Date that is the date of issue. This Group Policy is delivered in, and subject to the laws of the Jurisdiction in which it is issued.

PLEASE READ THIS GROUP POLICY CAREFULLY FOR FULL DETAILS.

This Group Policy is a legal contract and is issued in consideration of the Group Application of the Policyholder, a copy of which is attached, and of the full payment of premiums due. The following pages, including any riders, endorsement, schedule pages, Insured's enrollment forms, applications or amendments, form a part of this Group Policy.

In Witness Whereof, We have caused this Group Policy to be signed by



President

Table of Contents

Non-Participating

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

Schedule of Eligibility

Name of Policyholder: [AC Company]

Address: [123 Any Street, Any City, Any State]

Policy Number: [1234]

Policy Date: [September 1, 2008] All coverage begins and ends at 12:01 AM at the Policyholder's address.

Policy Anniversary: [ ]

Policy Year: The 12 consecutive month period starting on the Policy Date (or the Policy Anniversary) for subsequent Policy Terms.

Jurisdiction: [Any State]

Eligible Classes:

Eligible Participating Entities:

The following individuals are eligible to become insured under this Group Policy:

[Class - Description of Class as defined by the Employer/Policyholder]

Schedule of Premiums

[Employee Only	$ 55.17]
[Employee Plus One	$ 122.47]
[Employee& Family	$ 195.37]

POLICY PROVISIONS

Entire Contract; Changes: This Group Policy, including the endorsements, application, enrollment form, Certificate and the other attached papers, if any, constitutes the entire contract of insurance. No change in this Group Policy shall be valid until approved by Our Executive Officer and unless such approval be endorsed hereon. No agent has authority to change this Group Policy or to waive any of its Provisions.

All statements made by the Policyholder or Insured are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be Used as a defense to a claim unless a copy of the instrument containing the statement is in writing and signed by the Policyholder or the Insured, if applicable, and is or has been furnished to such Policyholder or Insured, if applicable.

Incontestability: After two (2) Years from the Policy Effective Date no statement, except a fraudulent misstatement, will cause the Group Policy to be contested.

Policy Period: The premium due for this Group Policy shall be remitted to Us by an Officer of the Policyholder authorized to remit premiums. The premium bases and rates are as stated in the Schedule of Premiums are due and payable [monthly] on the first day of each [month].

(1) **Change of Premium Rates:** We may, by written notice to the Policyholder at least 31 days in advance, change the rate at which further premiums, including the one then due, shall be computed. The new rate will not be based on this Group Policy's loss experience.

(2) **Grace Period:** A Grace Period of thirty-one days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy will continue in force, subject to Our right to cancel in accordance with Provision entitled "Cancellation". The Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force.

Certificate of Insurance: We shall issue to the Policyholder for delivery to each Insured, an individual Certificate that shall state the essential features of Insurance to which such a person is entitled and to whom benefits are payable when his or her insurance becomes effective.

Data Furnished by the Policyholder: If requested to do so by Us, the Policyholder shall furnish Us with the names of all persons initially insured, of all new persons who become insured, and of all Insureds whose insurance is cancelled, together with the data necessary for the calculation of premium. Failure on the part of the Policyholder to furnish the name of an Insured to Us shall not invalidate his or her insurance; nor shall failure on the part of the Policyholder to report termination of insurance of a person continue such insurance in force beyond the date of termination.

Examination and Audit: We shall be permitted to examine the Policyholder's records relating to the Group Policy at any time during the Policy term and within three Years after expiration of the Policy or until final adjustment and settlement of all claims hereunder, whichever is later.

Cancellation: After the first anniversary, We may cancel this Policy at any time by written notice delivered to the Policyholder or mailed to the last address as shown on Our records. The written notice shall state when, not less than 60 days thereafter, such cancellation shall be effective. After the Policy has been continued beyond its original term, the Policyholder may cancel this Policy or the Participating Entity may cancel its program under this Policy any time by written notice delivered or mailed to Us effective on receipt or on such later dates as may be specified in the notice. Such notice must be provided at least 31 days prior to the cancellation date. In the event of such cancellation by either the Policyholder or Us, We shall promptly return on a pro rata basis the unearned premiums paid, if any, and the Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid. Such cancellation shall be without

prejudice to any claim origination prior to the Effective Date of such cancellation. We may also cancel the insurance available to a Participating Entity subject to the same conditions.

Renewal Subject to Company Consent: The Policy may be renewed for like periods with Our consent, by payment in advance by the Policyholder of the renewal premium determined on the basis of Our premium rate in force for this insurance at the beginning of renewal.

Additional Insureds: Newly eligible persons and their Dependents may be added to the Group, in accordance with the terms of the Policy.

Not in Lieu of Worker's Compensation: This Group Policy is not in lieu of and does not affect any requirement for coverage by Worker's Compensation insurance.

Assignment: The Group Policy is [non-]assignable. The Insured may [not] assign any of the Policyholder rights, privileges or benefits under the Group Policy [to a PPO network provider of services only].

INCORPORATED PROVISION

The Provisions of the attached Certificate and all amendments to this Group Policy after its Effective Date are incorporated into and made part of this Group Policy.

The Provisions listed below are shown in the Certificate and are hereby incorporated into and made a part of this Group Policy.

Schedule of Benefits
Definitions
Effective Date of Coverage
Conversion
General Provision
Coverage Descriptions
Exclusions and Limitations

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Insured Persons who are **residents** of the State of Arkansas on the Certificate Date and on the date the claim is incurred.

RENEWABILITY

This Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew this Certificate because of any change in a Covered Person's health or physical condition. We may refuse to renew the coverage of a covered member or dependent if:

(a) the member fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(b) the covered member or dependent has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the health benefit plan, including claims for benefits under the health benefit plan;

(c) We cease to offer health benefit plan coverage in the association market and offer the option to purchase any other benefit plan; or

We may discontinue offering all health benefit to associations only if, at least 180 days before the date the coverage will expire, We:

Provide notice in writing to the commissioner of insurance, each association and each covered member;

Discontinue and do not renew all health benefit plans issued in this state and

Act uniformly without regard to any health status-related factor of covered members or dependents of covered members.

Medicare eligibility or entitlement is not a basis for non-renewal or termination of a health benefit plan issued to an association member. However, benefits may be subject to the Coordination of Benefits Provision.

If this Certificate is terminated in accordance with the above condition, a Covered Person's coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will send written notice of any termination or non-renewal including the reasons for non-renewal or termination of this Certificate by certified mail not less than 90 days prior to the non-renewal or termination, except for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

In Section 7, the following Mandated Benefits will be included

I. BENEFITS FOR DIABETES COVERAGE

Benefits will be paid the same as any other Sickness for Diabetes. Included is medical coverage for medically necessary equipment, supplies and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a licensed physician.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

II. BENEFITS FOR SELF-MANAGEMENT TRAINING COVERAGE

Benefits will be paid the same as any other Sickness for Diabetes Self-Management Training. One diabetes self-management training is covered per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.

In addition, additional diabetes self-management training is offered in the event that a physician prescribes additional diabetes self-management training and it is medically necessary because of a significant change in the insured's symptoms or conditions.

A licensed health care professional shall only provide diabetes self-management training within his or her scope of practice after having demonstrated expertise in diabetes care and treatment and after having completed an educational program required by his or her licensing board when that program is in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Diabetes self-management training shall be provided only upon prescription by a physician licensed.

Nothing in this provision shall be construed to prohibit us from selectively negotiating contracts with qualified providers of diabetes self-management training programs.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

III. [BENEFITS FOR CHILDRENS PREVENTIVE HEALTH CARE

Benefits will be paid the same as any other Sickness for Children's Preventive Health Care. Minimum basic benefits offered shall provide basic levels of primary, preventive, and hospital care, including the following:

1. Fifteen (15) days of inpatient hospitalization coverage per policy year;

2. a. Prenatal care, including:
   i. One (1) prenatal office visit per month during the first two (2) trimesters of pregnancy,
   i. Two (2) office visits per month during the seventh and eighth months of pregnancy, and
   iii. One (1) office visit per week during the ninth month until term.

   b. Coverage for each office visit shall include:
   i. Necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member; and
   ii. Such prenatal counseling as the physician deems appropriate;

3. Obstetrical care, including physicians' services, delivery room, and other medically necessary hospital services;

4. Coverage for children's preventive health care services are offered on a periodic basis from birth through age six (6) including thirteen (13) visits at approximately the following age intervals: birth, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, and six (6) years.

This benefit provides that children's preventive health care services which are rendered during a periodic review shall:

1. Only be covered to the extent that these services are provided by or under supervision of a single physician during the course of one (1) visit; and
2. Be reimbursed at levels established by the Insurance Commissioner which shall not exceed those established for the same services under the Medicaid program in the State of Arkansas.

5. A basic level of primary and preventive care, including two (2) office visits per calendar year for covered services rendered by a provider licensed to provide the services rendered;

6. Annual, lifetime, or other benefit limits shall be not less than one hundred thousand dollars ($100,000) as an annual benefit, and two hundred fifty thousand dollars ($250,000) as a lifetime benefit;

7. a. Newborn infant children are covered from the moment of birth and for adopted minors from the date of the interlocutory decree of adoption;

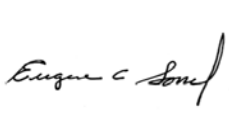
b. We require that the insured give notice of any newborn children within ninety (90) days following the birth of the newborn infant and of any adopted child within sixty (60) days of the date the insured has filed a petition to adopt. The coverage of newborn children or adopted children shall not be less than the same as is provided for other members of the insured's family.

Benefits will be subject to all Deductible, co-payment, coinsurance, limitations or any other provisions of the policy.

This endorsement takes effect and expires concurrently with the policy or certificate to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

There are no other changes to the certificate.

In Witness Whereof, We have caused this Endorsement to be signed by



President

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

GROUP HOSPITAL-MEDICAL-SURGICAL EXPENSE INSURANCE CERTIFICATE OF INSURANCE

Continental American Insurance Company, herein referred to as We, Us, or Our, certifies that the person named in the Certificate Schedule, herein referred to as You, is insured for the benefits described in this Certificate. This insurance is subject to the eligibility, any applicable Waiting Period, and Effective Date requirements contained in the Group Policy.

Your insurance is effective at 12:01 a.m. Standard Time at the address of the Group Policyholder on the Certificate Effective Date shown in Your Certificate Schedule.

TEN DAY FREE LOOK

You may cancel the insurance described in this Certificate at any time during the 10 day period after You receive this Certificate. Mail this Certificate with Your written request for cancellation to Our Agent or Us. We will promptly refund the premium paid and the insurance will be void.

IMPORTANT NOTICE

This Certificate is a summary of the Group Policy Provisions that affect Your insurance. It is merely evidence of the insurance provided by such Policy. The Group Policy is a contract between the Group Policyholder and Us. It may be changed or ended without notice or consent of any Insured.

This Certificate replaces any Certificate previously issued by Us to You under the Group Policy.

The benefits described in this Certificate are provided by the Group Policy Number shown on the Schedule and issued to the Group Policyholder whose name is shown on the Schedule.

READ YOUR CERTIFICATE CAREFULLY.

THIS COVERAGE PROVIDES LIMITED BENEFITS UP TO A CALENDAR YEAR MAXIMUM. PLEASE REVIEW YOUR SCHEDULE PAGE FOR BENEFITS.

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

TABLE OF CONTENTS

SECTION

SECTION 1- SCHEDULE OF BENEFITS

Insured - [John A. Doe]
Effective Date - [December 1, 1995]
Initial Premium - [$5.00 Monthly]
Group Policy Holder - [ABC Company]
Group Policy Number - [895]
Certificate Number - [51491]
First Renewal Date - [January 1, 1996]

Plan of Insurance	**In-Network**	**Out-of-Network**
Lifetime Plan Maximum [$5,000 - unlimited] per Insured		
Annual Plan Maximum [$5,000 - unlimited] per Insured		
[Calendar Year] Deductible (Individual/Family)	[$0-$100,000 / $0 - $300,000]	[$0-$100,000 / $0 - $300,000]

[Calendar Year] Deductibles apply to every expense listed below, unless otherwise noted.
Co-payments are not applied to the [Calendar Year] Deductible.
Any paid deductible is used to satisfy both in-network and out-of network requirements

In-Patient Care		
[Surgery-Inpatient, Physicians Services	[Surgery In-patient MD 20% - 100%]	[Surgery In-patient MD 20% - 100%]
[Hospital Inpatient (Facility)	[Hospital In-patient (Facility) 20%-100%]	[Hospital In-patient (Facility) 20%-100%]
[Other Hospital Charges (Including hospital based Professional charges) See Note (A)	[20%-100%]	[20%-100%]
[Physician Services (Inpatient visits)	[20%-100%]	[20%-100%]
[Maternity Care (You and covered Spouse only)	[20%-100%]	[20%-100%]
Out-patient Care -See Note (B)		
[Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	[$0-$150] Co-pay Then [20% - 100%]	[20% - 100%]
[Other Office Services provided during the Office Visit	[20% - 100%] No Calendar Year Deductible	[20% - 100%]
[Urgent Care Facility	[20% - 100%]	[20% - 100%]
[Surgery, Out-patient	[20% - 100%]	[20% - 100%]
[Maternity Care (You and covered Spouse only)	[20% - 100%]	[20% - 100%]
[Supplemental Accidental Benefit	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]]
[Emergency Room (if not admitted in-patient)	[20% - 100%] after [$0-$1000] Co-pay	[20% - 100%] after [$0-$1000] Co-pay]
[Cardiac, Occupational, Physical, Pulmonary & Speech Therapies and Chiropractic See Note (C)	[20% - 100%]	[20% - 100%]
[Transplant-Related Expenses	[0% - 100%	[0% - 100%]
[Routine Physical Exams, Pap Smears, Mammograms; PSA's See Note (D)	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit]	[20% - 100%]] No Calendar Year Deductible [$25-$750] Calendar Year Benefit]]

[Routine Well Child Care	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit	[20% - 100%] No Calendar Deductible] [$25-$750] Calendar Year Benefit]]
Others		
Mental Health	Not covered unless required by law	Not covered unless required by law
Substance Abuse Care	Not covered unless required by law	Not covered unless required by law

NOTES: (A): Other Inpatient Hospital Charges are subject to [$5,000-unlimited] Annual Maximum per Insured.
(B): Outpatient Care is subject to [$5,000-unlimited] Annual Maximum per Insured.
(C): Subject to [5-60] visits per category per [Calendar Year] per Insured.
(D): Routine Physical Exams include all related charges up to [$25-unlimited] Calendar Benefit.

Managed Care Program

Except for maternity admission, a participant or covered dependent is required to call a toll-free number upon learning of a future hospital admission, or to call within two working days after an emergency admission. This toll-free number is on the back of the plan's medical identification card. If this provision is not followed, then hospital charges and all charges related to the hospital admission will be subject to a [$250] per admission penalty, in addition to any deductible that may apply. Maternity admissions **do not** require certification. However, if the newborn baby stays longer in the hospital than the mother, the newborn's continuing hospital stay must be certified. Pre-certification of a hospital stay for medical necessity is not a guarantee of coverage or of payment of benefits. Coverage for benefits will only be determined when the claim is received, eligibility is verified, and it is determined that the benefits were in effect as of the time of service.

A Preferred Provider Organization (PPO) is an organization in which a Group of Hospitals and Physicians have agreed to provide medical care services to Insureds. The PPO for the Policy will be selected by Us. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to Policy Provisions. These benefits are payable at the In-Network benefit level. An Insured has the option to use a PPO Provider or a non-PPO Provider. If an Insured uses a non-PPO, benefits are payable at the Out-of-Network benefit level described above and subject to the out-of network deductible and coinsurance. If a PPO provider is used, auto assignment of benefits would apply unless payment in full is provided at claim submission.

For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the non-PPO level. However, if such treatment is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

Benefits payable under the Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its Providers and be paid directly to the Provider.

Benefits payable under the Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the Providers.

SECTION 2 – DEFINITIONS

Whenever used in the Group Policy:

Accident means: an occurrence which (a) is unforeseen; (b) is not due to or contributed to by a Sickness of any kind; and (c) causes Injury.

Actively-at-work means that on the day that coverage under the plan would begin, a member, or self employed independent contractor, is not absent from work, or if he or she is absent from work, the absence is not related to the health of the member.

[**Allogeneic (Allogenic) Transplant** means: a procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.]

Allowable Charges means: the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

[**Autologous Transplant** means: a procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.]

Complications of pregnancy means: the following:

a) Conditions requiring Hospital Confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; but the term shall **not** include: false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b) Ectopic pregnancy which is terminated.

[**Calendar Year:** A period of one year that starts on January 1 and ends at midnight on December 31st.]

Insured means: a person who is covered for benefits under the Group Policy while it is in effect and those Dependents covered for benefits under the Group Policy.

Deductible/Deductible Amount means: the dollar amount of Eligible Expenses an Insured must pay during each [Calendar Year] before benefits become payable.

Dependent means: Your:

a) married Spouse who lives with You and is under age 65; or
b) unmarried natural child, step child, foster child, adopted child or a child during the pendency of adoption who is not eligible for insurance as an Insured under the Group Policy and who:

    (1) is less than 19 Years old and is Dependent on You; or
    (2) is less than 25 and enrolled in an accredited school as a full-time student at a post-secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to Injury or Sickness. Such child will be covered so long as the coverage of the insured parent or guardian continues in effect and the child remains a Dependent of the parent or guardian.

(3) Becomes incapable of self-support because of mental retardation or physical handicap while insured under the Group Policy and prior to reaching the limiting age for Dependent children. The child must be Dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a Year after the child attains age [18-21] ; or
(4) Is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent does **not** include:

a) Your grandchild (except where required by law); or
b) A child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b) (2) above.

If a Dependent is eligible to be an Insured, he or she is not eligible as a Dependent.

In the event both parents of a Dependent child are Insureds, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

[Designated Facility means: a facility that We determine to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to You and Your Physician upon request.]

[**Durable Medical Equipment** consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, Hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Physician and be required for therapeutic use.

The following items are **not** considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair gliders, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.]

Elective Treatment means: medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Insured's Effective Date of coverage.

Elective treatment includes, but is not limited to; tubal ligation; vasectomy, breast reduction unless as a result of mastectomy; sexual reassignment surgery; sub mucous resection and /or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; learning disabilities; immunizations; botox injections, treatment of infertility and routine physical examinations.

Eligible Expense as used herein means: a charge for any treatment, service or supply which is performed or given under the direction of a Physician for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Group Policy is in force as to the Insured except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Service means: Health Care Services necessary to screen and stabilize an Insured in connection with an Emergency Medical Condition.

Experimental/Investigational means: a drug, device or medical care or treatment that meets the following:

a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a familiar function, if Federal or state law requires such review and approval;
d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

Geographic area means: the zip code in which the services, procedure, devise, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, devise, drug or supply.

Hospital means: a facility which meets all of these tests:

a) it provides in-patient services for the care and treatment of injured and sick people; and
b) it provides room and board services and nursing services 24 hours a day; and
c) it has established facilities for diagnosis and major surgery; and
d) it is supervised by a Physician; and
e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
f) it is accredited by the Joint Commission of Accreditation of Healthcare Organizations.

Hospital does **not** include a place run mainly: (a) as a convalescent home; or (b) as a nursing home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders or substance abuse or; (d) as a place for the aged unless written authorization is received.

The term Hospital includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Insured; (b) an ambulatory surgical center or ambulatory medical center (c) a mental health Hospital if supervised and licensed by the Department of Mental Health; and (d) a birthing facility certified and Licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital Confinement/Hospital Confined means: a stay of at least 18 consecutive hours or for which a room and board charge is made.

Immediate Family Member(s) means: a person who is related to the Insured in any of the following ways: Spouse, brother-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Injury means: bodily Injury due to an Accident which:

a) results solely, directly and independently of Disease, bodily infirmity or any other causes: and
b) All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

[**Intensive Care Unit** means: a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.]

Medical Necessity/Medically Necessary means: that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will **not** be considered as Medically Necessary if it:

a) is provided only as a convenience to the Insured or Provider; or
b) is not the appropriate treatment for the Insured's diagnosis or symptoms; or
c) exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
d) is Experimental/Investigated or for research purposes; or
e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual Center for Medicare and Medicaid Services Issues Manual; or
h) can be safely provided to the patient on a more cost-effective basis such as outpatient, by different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental or Nervous Disorder(s) means: any condition or Disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder (other than those conditions deemed serious Mental Illness, as defined in the Group Policy) on the date the medical care or treatment is rendered to an Insured.

One Sickness means: a Sickness and all recurrent and related conditions that are sustained by an Insured.

[**Orthopedic Brace and Appliance** means: a supportive device or appliance used to treat a Sickness or Injury.]

Personal Item means: an item that is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

Physician as used herein means:

a) legally qualified person licensed by the state in which he or she practices; and
b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and
c) certified nurse midwives and licensed midwives while acting within the scope of that certification.

The term Physician does **not** include an Insured's Immediate Family Members.

[**[Plan Year]** means: the consecutive 12-month period starting with the Effective Date shown in the Schedule of Benefits. Subsequent [Plan year] run from the anniversary date of Your Effective Date.]

Pre-existing condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the enrollment date. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

Pregnancy shall not be considered a pre-existing condition hereunder

A newborn child, a child placed for adoption, or a newly adopted child under age 18 who begins dependent coverage hereunder within 30 days of birth, placement for adoption, or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

Reasonable and Customary means: the charge, fee or expense which is the smallest of the:

a) actual charge;
b) charge usually made for a covered service by the Provider who furnishes it;
c) negotiated rate, if any;
d) prevailing change made for a covered service in the geographic area by those of similar professional standing as determined by the 90th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies.

Sickness means: a disease or illness including related conditions and recurrent symptoms of the Sickness that begins after the Effective Date of an Insured's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or related cause are considered one Sickness.

Sound Natural Teeth means: natural teeth, the major portion of the individual tooth that is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

Spouse means: Your legal Spouse [or Domestic Partner if recognized by state law.].

Tandem Transplant means: a procedure that requires the patient to undergo two planned autologous stem cell transplants within 6 months. Stem cells are collected once before initial high intensity chemotherapy or radiation therapy. Half of the stem cells are thereafter used for an initial stem cell transplant and the second half are used after recovery from the first procedure.

[Totally Disabled and Total Disability means: with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, it means that the Dependent cannot perform the normal activities of a person of like age and sex.]

[**Urgent Care Facility** means: a licensed facility that provides a variety of medical, surgical and/or pediatric services on an ambulatory emergency or non-emergency basis where the conditions being treated do not require inpatient confinement. Treatment must be under the supervision of a Physician and the facility must include a resident graduate nurse on staff.]

Waiting Period means: The continuous length of time that You must be Actively at Work before becoming eligible to enroll for coverage.

SECTION 3 – EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND ENROLLMENT

You: You are eligible for coverage when You satisfy the Waiting Period, complete a valid [application][enrollment form], and pay the initial premium.
Dependent: A Dependent is eligible for coverage on the later of the date You:

a) become eligible for insurance; or
b) acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the later of the Certificate Effective Date if Your Spouse is Your legal Spouse on that date or the date of the marriage to You.

Natural Child: From moment of birth.

Adopted Child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.

Stepchild: On the date the child begins residing in Your home.

Special Enrollees

You shall be a ***special enrollee*** provided:

- You or your dependant lost other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage, reduction in benefits of the other coverage or you voluntarily terminate the coverage); or,

- Policyholder contributions toward such other coverage were terminated; or,

- You or your dependents were covered under a COBRA continuation provision and the COBRA continuation period has been exhausted.

Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a ***special enrollee***.

An otherwise eligible member who is not covered by the plan, an otherwise eligible member and dependent who are not covered by the plan, or a participant's dependent who is not otherwise covered by the plan may apply for coverage under the plan as a result of the acquisition of a new dependent by the member and shall be a ***special enrollee*** provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent.

A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Coverage for a ***special enrollee***, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall begin as of the first day of the calendar month following a timely enrollment request.

EFFECTIVE DATE

Insured: If You enroll within the Enrollment Period after first becoming eligible to enroll for coverage, Your insurance will take effect on the later of:

a) The date You enroll; or
b) The date You satisfy the Waiting Period, if any,

No coverage will go into effect until You have satisfied the Waiting Period.
Insured Deferred Effective Date: If an eligible person is not Actively at Work on the date his or her insurance under the Group Policy is otherwise to take effect, such insurance will take effect on the day after such person returns to active work.

Dependent, except Dependents Acquired after the Effective Date: The Effective Date of coverage for a Dependent is shown in the Schedule of Benefits. In no event will Dependent coverage become effective prior to the date Your coverage becomes effective.

RENEWABILITY

This Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew the Group Policy because of any change in an Insured's health or physical condition. We may, at Our option, decline to renew the Certificate if We decline to renew the Group.

Unless the Certificate is renewed as stated in this Provision, coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will send written notice of any termination or non-renewal including the reasons for non-renewal or termination of this Certificate by certified mail not less than 60 days prior to the non-renewal or termination, except for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

TERMINATION

An Insured's coverage will terminate at 12:01 a.m. Standard Time at Your home on the earliest of the following:

a) The date the Group Policy terminates or the date a policyholder or sponsoring entity terminates coverage under the Group Policy;
b) The date coverage is terminated by Us for all certificate holders in Your state;
c) The date We receive Your written request to have Your insurance terminated;
d) The end of the period for which premium is paid, subject to the Grace Period;
e) The date an Insured enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces.
f) With respect to a Dependent Spouse, the date the Spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.
g) With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

SECTION 4 - LOSS OF COVERAGE

Loss of Coverage for Incapacitated Children

Dependent children, insured herein, who reach the limiting age, while covered hereunder, and are incapable of self-sustaining employment due to mental or physical handicap, may continue to be covered regardless of age. The Dependent child must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once every [Calendar Year].

Coverage for a handicapped Dependent child will end on the earliest of:

a) The date the child marries.
b) The date the child obtains self- sustaining employment.
c) The date the child ceases to be handicapped.
d) The date the child ceases to be chiefly dependent upon You.
e) Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days.
f) The date You refuse to allow Us to examine the child.

The date coverage under this Certificate would otherwise terminate.

Termination and Available Coverage After Termination -- COBRA

When a policyholder is required to comply with the federal law on continuation of coverage known as "COBRA," all eligible Insureds and dependents covered under this Certificate on the date before a qualifying event who would otherwise have lost coverage herein as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to your coverage while you have coverage under COBRA if the Policy would otherwise allow such a child to be covered by the Certificate. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the Insured, such child shall be considered a qualified beneficiary under the Certificate.

The Policyholder will notify the policy administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he becomes entitled to benefits under Title XVIII of the Social Security Act within 30 days of the occurrence of any of these events. You or Your covered dependent must notify the policy administrator within 60 days of his divorce or legal separation or when a dependent child is no longer eligible for coverage as defined in the Policy, in order for continuation coverage to be offered to the dependent.

The policy administrator will notify You or Your covered dependent of Your right to elect to continue coverage within 14 days from the date the policy administrator is first notified of any of the events described above. The election period shall begin no later than the date on which coverage terminates under the Policy due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

- The date coverage terminates under the Policy due to any qualifying event listed below, or

- The date the policy administrator sends notification to the Insured or covered dependent of his rights under this provision as described above.

Pursuant to the Trade Act of 1974, workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive Trade Act Assistance ("TAA") and may elect continuation coverage during a 60 day period that begins on the first day of the month in which he or she is determined to be a TAA eligible person. The person may elect coverage for himself and his family. The election must be made not later than 6 months after the date of TAA related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date which the coverage originally ended.

Benefits will be identical to those available under this Policy to all active Insureds and covered dependents that are similarly situated beneficiaries.

We require You and/or Your covered dependent pay for all or part of the cost for continuing the coverage, not to exceed 102% of the premium. Payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- The death of the participant,
- The divorce or legal separation of the participant from the covered dependent spouse,
- The participant becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or
- With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the Policy.

You and Your covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- Your employment with the policyholder terminates (except if due to the participant's gross misconduct), or

- You are laid off or Your working hours are reduced so as to render him ineligible for coverage as defined in the Policy.

If the You or Your covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

- The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;

- The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within the later of 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage, and before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within 30 days after the final determination is made that the person is no longer totally disabled; and

- The cost for coverage for months one through 18 will be at the rate of 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

- When You or Your dependent fails to make the required contribution (if any) to the plan administrator before the due date or within a grace period of 30 days;

- When the policyholder or covered dependent first becomes covered by any other group health Policy, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;

- When the policyholder ceases to maintain any group health Policy; or

- In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled.

A retired Insured and his or her spouse who would otherwise lose health coverage under the Policy after the policyholder files a Chapter 11 bankruptcy proceeding may continue coverage under the Policy until the death of the insured. Upon the death of the retired covered insured, his covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

If Your or Your dependent first becomes covered under another group health Policy or Medicare while covered hereunder, continuation coverage may continue only during the time that the new group health Policy contains any exclusion or limitation which relates to a pre-existing condition of the insured or dependent. Normal payments for this coverage must be made in order for continuation coverage to remain in effect.

Any other group health Policy will be considered the primary coverage and must always pay benefits before this Policy will consider a claim for benefits. The only exception is that the Policy will remain primary if the COBRA covered person is covered by Medicare by reason of end stage renal disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period, another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

CERTIFICATES OF CREDITABLE COVERAGE

We will issue Certificates of Creditable Coverage for each Insured whose coverage under the Group Policy is terminated. In addition, Certificates shall be issued when requested by an Insured, so long as such request is made within 24 months after cessation of coverage under the Group Policy. Such issuance will occur within a reasonable time.

SECTION 5 – GENERAL PROVISIONS

Grace Period: No Grace Period is allowed for the first premium. A Grace Period of 31 days is allowed for payment of each premium due after the first premium. We will continue Your insurance during the Grace Period. However, if We do not receive Your payment by the end of the Grace Period, Your coverage will terminate retroactive to the premium due date that You failed to pay the required premium. The Grace Period will not continue coverage beyond a date stated in the Termination Provisions.

Notice of Claim: Written notice of claim must be given to Us or Our authorized representative within 90 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Insured.

Claim Forms: We, upon receipt of written notice of claim, will furnish to the Claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the Claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us or Our authorized representative within 90 days after the covered loss. If proof of loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise required or the claim will be denied.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless this Certificate provides for periodic payment.

Payment of Claims: Benefits unpaid at the Insured's death may, at Our option, be paid either to such beneficiary or to the Insured's estate. All other benefits will be payable to the Insured.

If any benefit of this Certificate is payable to an Insured's estate, or to someone who is a minor or otherwise not competent to give a valid release, then We may pay up to $1,000 to any relative by blood, or connection by marriage to the Insured or to the beneficiary who is deemed by Us to be equitably entitled to it. Any such payment made in good faith shall fully discharge Us to the extent of such payment.

Unpaid Premium - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Physical Examination: We, at Our own expense, shall have the right and opportunity to examine an Insured as it may reasonably require while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 Years from the time written proof was required to be given.

[Subrogation: When benefits are paid to or for You or for a Dependent under the terms of the Group Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured or Dependent against any person who might be acknowledge to be liable by a Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by Us of the benefits we have paid for such hospitalization and treatment]

Assignment: You may assign all of Your rights, privileges and benefits under the Group Policy. We are not bound by an assignment until We receive and file a signed copy. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and Federal laws and the terms of the Group Policy.

Medical Claim Payment and Appeals:

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the Insured will be notified of the policy administrator's decision as soon as possible, but no more than 72 hours after the policy administrator receives the claim. If the treating physician classifies a claim as "urgent," the Policy will do so as well.

Extensions:

If information to support a review of an "urgent" claim is incomplete, the following will occur;

- The policy administrator will notify the Insured of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.

- The Insured has 48 hours to provide the missing information or the review of the "urgent" pre-service claim will be closed.

- The policy administrator will make its decision within 48 hours after it receives all necessary information. If a supplemental submission of information is deficient, the time frames begin again.

If an Insured appeals the denial of a pre-service "urgent" claim, the policy administrator must render a review decision as soon as possible, but no more than 72 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Policy:

If a policy administrator has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the policy administrator must notify the Insured of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the Policy has been amended to reduce or end coverage for the treatment, or when the Policy itself terminates.

Extensions of Treatment:

When an Insured requests an extension of an on-going course of treatment beyond that which the policy administrator has approved, the policy administrator must do the following:

- Make a decision about the extension as soon as possible; and

- Notify the Insured of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Managed Care Program

The managed care program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

Pre-Certification Process

Participants or their dependents with the benefit of a managed care program must have every inpatient hospital stay, other than maternity, certified. This is a participant-driven and participant-responsible program. The participant or agent for the participant may call or have the admitting physician or hospital call to certify the stay. Medical, surgical and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within two working days of admission. Maternity admissions for deliveries **do not** require certification. If the newborn baby stays longer in the hospital than the mother, the newborn's continued hospital stay must be certified.

Except in the case of maternity, at the time a medical, surgical or psychiatric inpatient hospital admission is planned, the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre-certification. A penalty per admission as shown in the schedule of benefits will be reflected to the participant if pre-certification requirements are not followed.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

- Plan participant name
- Company name
- Patient's name and age
- Admitting physician's name, address and phone number
- Name of hospital and address

Calls received after hours will be recorded, and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two working days of the emergency admission.

Concurrent Review

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The pre-certification unit staff will monitor the patient's progress throughout the hospital stay to assure discharge is not delayed by inadequate planning and that each day of confinement is medically necessary and appropriate.

The pre-certification staff will contact the hospital utilization review department or the admitting physician for information if additional days are needed beyond those days initially certified. This concurrent review will continue until the patient is discharged.

Inpatient days certified at admissions DO NOT determine the length of inpatient stay. Only the attending physician determines when a patient is to be discharged. The days anticipated at admission may not be needed, or an extension of inpatient days may be required. The physician determines this.

The appeal process is available for a patient's physician when a determination is made that additional days of inpatient care are not medically necessary.

Pre-Service Benefit Claim Review for Coverage

If the policy administrator requires that benefits for a service be predetermined prior to the service being provided, the Insured or the health care provider must submit a request for that pre-service benefit claim review to the policy administrator. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15-day period may be extended for another 15 days if it is necessary because of matters beyond the Policy's control, and if the policy administrator notifies the Insured of those circumstances and the expected date of the decision before the end of the first 15-day period.

- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the Insured 45 days to submit such information.

Normal Post-Service Health Claims

An Insured or health care provider must file a claim with the policy administrator within the time frames set out in the Policy. A claim will be considered to have been filed upon receipt by the policy administrator. The Insured will be notified within 30 days of receipt of a claim by the policy administrator as to the benefits to be paid for that claim.

Extensions:

- The 30-day period may be extended for 15 days if it is necessary due to matters beyond the control of the policy administrator, but the policy administrator will notify the Insured before the end of the 30-day period of those circumstances and the expected date of the decision.

- If more information is necessary to properly process the claim, a notice will be given within the 30-day period that the policy administrator can not meet the 30-day time frame. The notice will describe the missing information and give the Insured at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45-day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the Policy.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the policy administrator, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;

- A reference to any specific Policy provisions on which the determination is based;

- A description of any additional material or information necessary for the Insured to make the claim payable and an explanation of why such material or information is necessary;

- A description of the policy administrator's review procedures and the time limits which are applicable to such procedures, including a statement of the Insured's right to bring a civil action under Section 502(a) of ERISA;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Policy will provide that criterion free of charge upon request; and

- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the policy administrator will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the policy administrator will do the following:

- Allow an Insured 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the policy administrator at the address found in the summary Policy description;

- Allow an Insured the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Provide an Insured, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the Insured's claim for benefits;

- Provide for a review that takes into account all comments, documents, records, and other information submitted by the Insured relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Policy who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual
- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate policy administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained on behalf of the Policy in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

- Notify the Insured of the policy administrator's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the Insured's appeal, unless the policy administrator determines that special circumstances require an extension of time for processing the appeal.

SECTION 6 - COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does **not** include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Insured is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured is not an Allowable expense.

The following are examples of expenses that are **not** Allowable expenses:

(1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If an Insured is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If an Insured is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If an Insured is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that

provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because an Insured has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the [calendar year] excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When an Insured is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired member); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the [calendar year] is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to [calendar year] commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Member or Retired or Laid-off Member. The Plan that covers a person as an active member, that is, a member who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off member is the Secondary plan. The same would hold true if a person is a dependent of an active member and that same person is a dependent of a retired or laid-off member. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an member, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a [Calendar year] are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If an Insured is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The policy administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. The policy administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give The policy administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, The policy administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The policy administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by The policy administrator is more than it should have paid under this COB provision or for any amount paid out as a part of normal claim payments, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 7 – COVERAGE DESCRIPTIONS

All benefits under the Group Policy are shown in the Schedule of Benefits. The Schedule of Benefits also shows You the annual Plan Maximums, Lifetime Maximums, deductibles and co-payments per Insured for each benefit provided. The benefits are described and governed by the pages attached to and made a part of the Group Policy. For In-Network Eligible Expenses, benefits are payable at the percentage shown in the Schedule of Benefits for each benefit provided. For Out-of-Network Eligible Expenses, benefits are payable at the percentage shown for the Reasonable and Customary charges incurred.

[**INPATIENT CARE**
[If an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for Surgery, Physicians Services, Hospital Inpatient (including room and board, surgeon services and anesthesia), or Other Hospital Charges, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Benefits for Hospital care include Eligible Expenses incurred for Hospital Room and Board Expense, Intensive Care, and Other Hospital Charges for Miscellaneous Hospital Expense including for anesthesia and operating room; laboratory tests and X-rays; oxygen tent; drugs, medicines, dressings and other Durable Medical Equipment and other Medically Necessary and prescribed Hospital Expenses. If while confined as an inpatient an Insured requires the services of a Physician other than a Physician who perform surgery on, or administered anesthesia to, the Insured, We will pay a benefit for Physician Services.]

[We will also pay benefits for Surgical Expenses. Surgical Expense means charges by a Physician for:

a) a Surgical Procedure;
b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
c) usual postoperative treatment.

Surgical Procedure means:

- a cutting procedure;
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- radiotherapy (excluding radioactive isotope therapy)
- cutting operation for removal of a tumor;
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures;
- injection treatment of hemorrhoids and varicose veins;
- an operation by means of laser beam;
- casting;
- removal of a foreign body;
- drainage or aspiration;
- implant;
- catheter placement;
- microsurgery

The maximum benefit payable and co-payment amounts are shown in the Schedule of Benefits.

When an Assistant Surgeon is required to render technical assistance at an operation, the Schedule of Benefits will apply when services are provided by a network provider and if a non-network provider is used, the eligible expense for such services shall be limited to 25% of the reasonable and customary charge for the surgical procedure

If multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s).

Treatment performed outside the Hospital will be paid the same as if performed in a Hospital provided it would have been covered on an inpatient basis.]

[**BENEFITS FOR MATERNITY**

Maternity benefits are available to You and Your Spouse only.

When an Insured is confined to a Hospital as a resident inpatient for childbirth, We will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

a) 48 hours after a non-cesarean delivery; or
b) 96 hours after a cesarean section;

for the mother and the newborn infant(s), unless, at the mother's option, an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. We will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

In the event such earlier discharge occurs, at least one home visit will be available to the mother, and not subject to any deductibles, coinsurance, or co-payment.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) will be conducted within 24 hours following:

a) discharge from the Hospital; or
b) the mother's request; whichever is later.

Benefits include:

a) parent education;
b) assistance and training in breast or bottle feeding; and
c) the performance of any necessary maternal and newborn clinical assessments.]

One ultrasound test will be payable per pregnancy without any additional diagnosis. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary. In addition, for a female Insured over 35 Years of age, charges for the following tests may be considered Eligible Expenses:

- Amniocentesis/AFP Screening;
- Chromosome testing; and
- Fetal stress/non-stress tests.

This Provision is subject to all of the terms of the Group Policy.]

[**OUTPATIENT EXPENSE**
If, by reason of Injury or Sickness, an Insured requires Medically Necessary treatment in a Physician's office, Urgent Care Facility, or licensed ambulatory surgical facility, We will pay the benefits for the treatment and other office services related to such treatment. Treatment of pregnancy is on the same basis as any other Sickness. Benefits include diagnostic X-ray and laboratory examinations, and radiotherapy.

The Covered Percentage, deductible, co-payments and Plan maximums are shown in the Schedule of Benefits.

If the services are in connection with surgery and the Physician is the surgeon who performed the surgery, no benefits are payable under this Provision.

Benefits are payable for Eligible Expenses incurred for the following tests:

- pregnancy tests;
- CBC;

- Hepatitis B Surface Antigen;
- Rubella Screen;
- Syphilis Screen;
- Chlamydia;
- HIV;
- Gonorrhea;
- Toxoplasmosis;
- Blood Typing ABO;
- RH Blood Antibody Screen;
- Urinalysis;
- Urine Bacterial Culture;
- Microbial Nucleic Acid Probe;
- AFP Blood Screening;
- Pap Smear;
- Glucose challenge Test (at 24 weeks gestation); and
- PSA

[**PREVENTIVE CARE**
Benefits are payable for Eligible Expenses incurred by an Insured for the following preventive care. The charges must be incurred while an Insured is insured for these benefits. The annual maximum benefit and co-payment are shown in the Schedule of Benefits. The deductible provision does not apply to these benefits.

Cervical cytology screening and screening mammography

Eligible Expenses include the following:

a) in the case of benefits for cervical cytology screening, annual screening for women (18) eighteen Years of age and older. This coverage shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection, with examining and evaluating the Pap smear.

b) In the case of mammograms:

   1) a baseline mammogram for women at least age 35 but Younger than 40 Years of age.
   2) a mammogram every two Years for asymptomatic women age 40 but Younger than 50 Years of age or more often if recommended by the patient's Physician.
   3) A mammogram every Year for women age 50 or older.

Screening mammography means radiological examination of the breast of asymptomatic women for the early detection of breast cancer, which examination shall include:

a) a cranio-caudal and a medial lateral oblique view of each breast; and
b) a licensed radiologist's interpretation of the results of the procedure. Screening mammography shall not include diagnostic mammography, additional projections required for lesion definition, breast ultrasound, or any breast interventional procedure. Screening mammography shall be performed by a mammogram supplier who meets the standards of the Federal Mammography Quality Standards Act of 1992.

Routine Annual Examination for Adult Insured: Benefits are also payable for one annual check-up to a Physician per Insured for a wellness visit. Benefits include all related charges up to the amount shown in the benefit schedule.

Routine Well Child Care Benefits: Benefits are payable for child wellness services which are rendered during a periodic review are covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one visit. Covered services include: medical history; measurement of height, weight and head

circumference; testing of blood pressure; sensory screening including vision and hearing; hereditary and metabolic screening in accordance with state law; developmental/behavioral assessment; immunizations consistent with prevailing American Academy of Pediatric Committee statements; tuberculin test; hematocrit or hemoglobin; urinalysis; and anticipatory guidance.]

[EMERGENCY ROOM SERVICES
Subject to any co-payment, if an Insured incurs Eligible Expenses in a Hospital Emergency Room for treatment of a medical emergency due to Injury or Sickness, we will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers. The co-payment is waived if the Insured is admitted to the Hospital as an inpatient.]

[SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are payable if an Insured incurs Eligible Expenses for treatment of a medical emergency due to an Accident, we will pay the benefits shown on the Schedule of Benefits on the percentages shown for In-Network or Out-of-Network Providers.]

[CARDIAC, OCCUPATIONAL, PHYSICAL, PULMONARY, SPEECH THERAPIES, AND CHIROPRACTIC CARE
Subject to any co-payment and deductible requirements, if an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for cardiac, occupational, physical, pulmonary, and speech therapies and chiropractic care, we will pay the benefits shown in the Schedule of Benefits. The treatment must be for rehabilitation, must be Medically Necessary, and be prescribed by a Physician.

These services/therapies each has a benefit maximum of 20 visits per Insured, per [plan year] whether provided on an out-patient or inpatient basis. The benefit maximum renews each [plan year].

Each treatment date counts as one visit for each service provided, even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides You with physical therapy and occupational therapy on the same day, the services are counted as one visit for physical therapy and one visit for occupational therapy. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied toward the maximum benefit limit.

Physical therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a neuromuscular condition that can be significantly improved within a 6-month period of time.

We pay for physical therapy performed by:

- A doctor of medicine, osteopathy or podiatry
- A dentist for the oral-facial complex
- An optometrist for services for which they are licensed
- A certified nurse practitioner
- A licensed physical therapist under the direction of a Physician
- Other individuals under the direct supervision of a licensed physical therapist, MD or DO or
- A licensed independent physical therapist

Services do not include:

- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program

- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy
- Physical therapy performed by a chiropractor except mechanical traction

Speech and language pathology services must be:

- Prescribed by a Physician licensed to prescribe them
- Given for a condition that can be significantly improved within 6-months
- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist.

The clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

Occupational Therapy must be:

- Prescribed by a Physician licensed to prescribe it and
- Given for a condition that can be significantly improved within 6 months and
- Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of in which he or she practices). The occupational therapy assistant must be under the direct supervision of a registered occupational therapist, who cosigns all assessments and patients' progress notes.

Services do **not** include:

- Occupational therapy examinations or evaluations without an occupational therapy treatment plan and where there is no progress
- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- Recreational therapy

Cardiac Rehabilitation Therapy includes intensive monitoring (EKGs) and/or supervision during exercise in a Physician-directed clinic (one in which a Physician is on-site).

Chiropractic services include manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, applications of heat or cold by a Physician or chiropractor.

Pulmonary Therapy includes respiratory therapies prescribed by a Physician as Medically Necessary treating Insureds with chronic breathing problems that include:

- Asthma
- Emphysema
- COPD (Chronic Obstructive Pulmonary Disease)
- Sarcoidosis
- Cystic Fibrosis
- Pulmonary Fibrosis
- Chronic Bronchitis
- Interstitial lung Disease

- Pre and post lung volume reduction surgery
- Bronchiectasis
- Other cardiopulmonary disorders]

[**TRANSPLANT RELATED EXPENSES**
Subject to any deductible payment, if an Insured incurs Transplant related Eligible Expenses, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Allogenic Transplants
We will pay the Reasonable and Customary expenses incurred for allogenic transplants as follows:

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is: a) A first degree relative and matches at least four of the six important HLA genetic markers with the patient; or b) Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This Provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.) Harvesting and storage will be covered if it is not covered by the donor's insurance. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants
We will pay the Reasonable and Customary expenses incurred for autologous transplants as follows:

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of "Tandem Transplant" in the Definitions Section.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Aplastic anemia
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency Disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)

- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Megakaryocytic thrombocytopenia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucolipidoses (e.g., Gaucher's Disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's Disease (high risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

NOTE: In addition to the conditions listed above, We will pay for services related to, or for high dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage to antineoplastic drugs when a state law requires that these drugs, and the reasonable cost of their administration, be covered.

We do **not** pay the following for bone marrow transplants:

- Services that are not Medically Necessary
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- An allogeneic tandem transplant
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

Specified human Organ Transplants
When performed in a designated facility, We pay for transplantation of the following human organs:

Combined small intestine-liver
Heart
Heart-lung(s)
Liver
Lobar lung
Lung(s)
Pancreas
Partial liver
Simultaneous pancreas-kidney
Small intestine (small bowel)

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided while coverage is in force under the Group Policy and such services must begin five days before and end one Year after the organ transplant to be covered.

When directly related to the transplant, We pay for:

Facility and professional services
Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed.

Medically Necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during a benefit period and is the direct result of the organ transplant surgery.

We do **not** pay for the following for specified human organ transplants:

- Services that are not covered benefits under the Group Policy
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
- Anti-rejection drugs that do not have a Food and Drug Administration marketing approval
- Transplant surgery and related services that are not performed in a designated facility. You must pay for the transplant surgery and related services You receive in a non-designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and Hospitalization
- Services prior to Your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under the Group Policy
- Experimental transplant procedures. See the definition of experimental treatment

SECTION 8- EXCLUSIONS AND LIMITATIONS

The following are not Eligible Expenses and not covered under the Group Policy:

1. [Injury arising out of or in the course of employment, or activity for wage or profit, or which is compensable under Workers' Compensation or Occupational Disease Act or Law.]
2. [Experimental or investigational services, drugs, or supplies except to the extent required by law;]
3. [Educational testing or training related to learning disabilities or developmental delays;]
4. [Custodial care or personal items;]
5. [Any expense incurred before the Effective Date of an insured's insurance under the Policy or after the termination date of an Insured's insurance.]

6. [Eye surgery to correct refractive errors;]
7. [Therapy, supplies, or counseling for sexual dysfunctions]
8. [Performance, or lifestyle enhancement drugs or supplies]
9. [Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered]
10. [Routine physical, vision, or hearing exams, immunizations, or other preventive services or supplies, except to the extent that coverage is specifically provided under the Group Policy;]
11. [Dental care except for Injury to sound natural teeth;]
12. [Elective surgery;]
13. [Cosmetic Surgery other than reconstructive Surgery incidental to or following surgery resulting from trauma, infection, or other Diseases of the involved part; or reconstructive surgery because of a congenital Disease or anomaly;or according to the requirements of the Women's Health and Cancer Rights Act]
14. [Speech therapy except as otherwise specifically covered under the Group Policy;]
15. [Inpatient or outpatient treatment of alcoholism, drug abuse, and mental illnesses; except where required by law]
16. [Private duty nursing;]
17. [An Injury sustained while the Insured is legally intoxicated or under the influence of alcohol as defined by the jurisdiction where the Accident occurred;]
18. [Charges made to treat a Sickness or Injury sustained while flying as a pilot or crew member;]
19. [Voluntary sterilization procedure or the reversal of a sterilization procedure;]
20. [Weight control services including surgical procedures, medical treatments, weight control/loss programs; food supplements or exercise programs or equipment; and]
21. [Intentionally self inflicted injury or action unless the result of a medical condition]
22. [War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.]
23. [Services and supplies not medically necessary, recommended or approved for the diagnosis, care, or treatment of the disease or injury involved by the treating physician.]
24. [Charges made for: manipulative (adjustive) treatment; or treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.]
25. [Prescription drugs and medicines prescribed by a physician [on an outpatient basis]]
26. [Charges in excess of the Recognized Charge, based on the 90th percentile of the Medicode Medical Data Research Tables.]
27. [Charges for any treatment received while in a skilled nursing facility will not be covered.]
28. [Charges for any treatment for Home Health Care, except as covered under maternity.]
29. [Transportation charges, including ambulatory services.]
30. [Charges for biofeedback.]
31. [Any Treatment received under hospice care.]
32. [Elective or voluntary abortions, except in the case of rape, incest or congenital deformities.]
33. [Charges for Prosthetics and/or orthotics.]
34. [Charges for Temporomandibular Joint Disorder (TMJ).]

PRE-EXISTING CONDITIONS: Expenses incurred for treatment of Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy.

Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy. This limitation will **not** apply if:

a) The individual seeking coverage under the Group Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage Credit will be given for the time the individual was covered under prior Creditable Coverage that is not separated by a break in coverage of 63 days or more; and
b) The individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

Pre-existing Conditions does **not** apply to:

a) a newborn Dependent child; or
b) a child adopted by the Insured or placed with the Insured for adoption, if adoption or placement for adoption occurs while covered under the Group Policy.

CREDIT FOR PRIOR COVERAGE: An Insured whose coverage under prior Creditable Coverage ended no more than 63 days before the Insured's Effective Date under the Group Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break. The Insured must provide proof of prior Creditable Coverage.

Creditable Coverage means coverage under any of the following:

a) Any individual or Group Policy, contract, or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured member Plan, or any other entity, and that arranges or provides medical, Hospital and surgical coverage not designed to supplement other private or governmental plans;
b) The Federal Medicare Program pursuant to Title XVIII of the Social Security Act;
c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
d) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);
e) a medical care program of the Indian Health Service or of a tribal organization;
f) a state health benefits risk pool;
g) a health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) Federal Employees Health Benefits Program (FEHBP);
h) a public health plan as defined under section 5(e) of the Peace Corps Act (22 U.S.C.A. Section 2504(e)); or
i) any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the Federal Public Health Services Act (42 U.S.C. Section 300gg(c)).

Creditable Coverage includes continuation or Conversion coverage but does **not** include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

GROUP HOSPITAL-MEDICAL-SURGICAL EXPENSE INSURANCE
CERTIFICATE OF INSURANCE

Continental American Insurance Company, herein referred to as We, Us, or Our, certifies that the person named in the Certificate Schedule, herein referred to as You, is insured for the benefits described in this Certificate. This insurance is subject to the eligibility, any applicable Waiting Period, and Effective Date requirements contained in the Group Policy.

Your insurance is effective at 12:01 a.m. Standard Time at the address of the Group Policyholder on the Certificate Effective Date shown in Your Certificate Schedule.

TEN DAY FREE LOOK

You may cancel the insurance described in this Certificate at any time during the 10 day period after You receive this Certificate. Mail this Certificate with Your written request for cancellation to Our Agent or Us. We will promptly refund the premium paid and the insurance will be void.

IMPORTANT NOTICE

This Certificate is a summary of the Group Policy Provisions that affect Your insurance. It is merely evidence of the insurance provided by such Policy. The Group Policy is a contract between the Group Policyholder and Us. It may be changed or ended without notice or consent of any Insured.

This Certificate replaces any Certificate previously issued by Us to You under the Group Policy.

The benefits described in this Certificate are provided by the Group Policy Number shown on the Schedule and issued to the Group Policyholder whose name is shown on the Schedule.

READ YOUR CERTIFICATE CAREFULLY.

THIS COVERAGE PROVIDES LIMITED BENEFITS UP TO A CALENDAR YEAR MAXIMUM. PLEASE REVIEW YOUR SCHEDULE PAGE FOR BENEFITS.

Any certificates issued in the State of Arkansas are governed by State of Arkansas.

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SECTION

SECTION 1- SCHEDULE OF BENEFITS

Insured - [John A. Doe]
Effective Date - [December 1, 1995]
Initial Premium - [$5.00 Monthly]
Group Policy Holder - [ABC Company]
Group Policy Number - [895]
Certificate Number - [51491]
First Renewal Date - [January 1, 1996]

Plan of Insurance	**In-Network**	**Out-of-Network**
Lifetime Plan Maximum [$5,000 - unlimited] per Insured		
Annual Plan Maximum [$5,000 - unlimited] per Insured		
[Calendar Year] Deductible (Individual/Family)	[$0-$100,000 / $0 - $300,000]	[$0-$100,000 / $0 - $300,000]

[Calendar Year] Deductibles apply to every expense listed below, unless otherwise noted.
Co-payments are not applied to the [Calendar Year] Deductible.
Any paid deductible is used to satisfy both in-network and out-of network requirements

In-Patient Care		
[Surgery-Inpatient, Physicians Services	[Surgery In-patient MD 20% - 100%]	[Surgery In-patient MD 20% - 100%]
[Hospital Inpatient (Facility)	[Hospital In-patient (Facility) 20%-100%]	[Hospital In-patient (Facility) 20%-100%]
[Other Hospital Charges (Including hospital based Professional charges) See Note (A)	[20%-100%]	[20%-100%]
[Physician Services (Inpatient visits)	[20%-100%]	[20%-100%]
[Maternity Care (You and covered Spouse only)	[20%-100%]	[20%-100%]
Out-patient Care -See Note (B)		
[Physician/Specialist Office Visit (Co-pay does not apply to any other service rendered in the office.)	[$0-$150] Co-pay Then [20% - 100%]	[20% - 100%]
[Other Office Services provided during the Office Visit	[20% - 100%] No Calendar Year Deductible	[20% - 100%]
[Urgent Care Facility	[20% - 100%]	[20% - 100%]
[Surgery, Out-patient	[20% - 100%]	[20% - 100%]
[Maternity Care (You and covered Spouse only)	[20% - 100%]	[20% - 100%]
[Supplemental Accidental Benefit	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]	[First $400 per Accident paid in full then [20-100%] not subject to the deductible]]
[Emergency Room (if not admitted in-patient)	[20% - 100%] after [$0-$1000] Co-pay	[20% - 100%] after [$0-$1000] Co-pay]
[Cardiac, Occupational, Physical, Pulmonary & Speech Therapies and Chiropractic See Note (C)	[20% - 100%]	[20% - 100%]
[Transplant-Related Expenses	[0% - 100%]	[0% - 100%]
[Routine Physical Exams, Pap Smears, Mammograms; PSA's See Note (D)	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit]	[20% - 100%]] No Calendar Year Deductible [$25-$750] Calendar Year Benefit]]

[Routine Well Child Care	[$0-$100] Co-pay Then [20% - 100%] [$25-$750] Calendar Year Benefit	[20% - 100%] No Calendar Deductible] [$25-$750] Calendar Year Benefit]]
Others		
Mental Health	Not covered unless required by law	Not covered unless required by law
Substance Abuse Care	Not covered unless required by law	Not covered unless required by law

NOTES: (A): Other Inpatient Hospital Charges are subject to [$5,000-unlimited] Annual Maximum per Insured.
(B): Outpatient Care is subject to [$5,000-unlimited] Annual Maximum per Insured.
(C): Subject to [5-60] visits per category per [Calendar Year] per Insured.
(D): Routine Physical Exams include all related charges up to [$25-unlimited] Calendar Benefit.

Managed Care Program

Except for maternity admission, a participant or covered dependent is required to call a toll-free number upon learning of a future hospital admission, or to call within two working days after an emergency admission. This toll-free number is on the back of the plan's medical identification card. If this provision is not followed, then hospital charges and all charges related to the hospital admission will be subject to a [$250] per admission penalty, in addition to any deductible that may apply. Maternity admissions **do not** require certification. However, if the newborn baby stays longer in the hospital than the mother, the newborn's continuing hospital stay must be certified. Pre-certification of a hospital stay for medical necessity is not a guarantee of coverage or of payment of benefits. Coverage for benefits will only be determined when the claim is received, eligibility is verified, and its determined that the benefits were in effect as of the time of service.

A Preferred Provider Organization (PPO) is an organization in which a Group of Hospitals and Physicians have agreed to provide medical care services to Insureds. The PPO for the Policy will be selected by Us. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to Policy Provisions. These benefits are payable at the In-Network benefit level. An Insured has the option to use a PPO Provider or a non-PPO Provider. If an Insured uses a non-PPO, benefits are payable at the Out-of-Network benefit level described above and subject to the out-of network deductible and coinsurance. If a PPO provider is used, auto assignment of benefits would apply unless payment in full is provided at claim submission.

For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the non-PPO level. However, if such treatment is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

Benefits payable under the Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its Providers and be paid directly to the Provider.

Benefits payable under the Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the Providers.

SECTION 2 – DEFINITIONS

Whenever used in the Group Policy:

Accident means: an occurrence which (a) is unforeseen; (b) is not due to or contributed to by a Sickness of any kind; and (c) causes Injury.

Actively-at-work means that on the day that coverage under the plan would begin, an employee, or self employed independent contractor, is not absent from work, or if he or she is absent from work, the absence is not related to the health of the employee.

[**Allogeneic (Allogenic) Transplant** means: a procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.]

Allowable Charges means: the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

[**Autologous Transplant** means: a procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.]

Complications of pregnancy means: the following:

a) Conditions requiring Hospital Confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; but the term shall **not** include: false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

b) Ectopic pregnancy which is terminated.

[**Calendar Year:** A period of one year that starts on January 1 and ends at midnight on December 31st.]

Insured means: a person who is covered for benefits under the Group Policy while it is in effect and those Dependents covered for benefits under the Group Policy.

Deductible/Deductible Amount means: the dollar amount of Eligible Expenses an Insured must pay during each [Calendar Year] before benefits become payable.

Dependent means: Your:

a) married Spouse who lives with You and is under age 65; or
b) unmarried natural child, step child, foster child, adopted child or a child during the pendency of adoption who is not eligible for insurance as an Insured under the Group Policy and who:

    (1) is less than 19 Years old and is Dependent on You; or
    (2) is less than 25 and enrolled in an accredited school as a full-time student at a post-secondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to Injury or Sickness. Such child will be covered so long as the coverage of the insured parent or guardian continues in effect and the child remains a Dependent of the parent or guardian.

(3) Becomes incapable of self-support because of mental retardation or physical handicap while insured under the Group Policy and prior to reaching the limiting age for Dependent children. The child must be Dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a Year after the child attains age [18-21] ; or
(4) Is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent does **not** include:

a) Your grandchild (except where required by law); or
b) A child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student as described in (b) (2) above.

If a Dependent is eligible to be an Insured, he or she is not eligible as a Dependent.

In the event both parents of a Dependent child are Insureds, such child is considered as a Dependent of either parent. The child may not be considered a Dependent of both parents.

[Designated Facility means: a facility that We determine to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to You and Your Physician upon request.]

[**Durable Medical Equipment** consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, Hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Physician and be required for therapeutic use.

The following items are **not** considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair gliders, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.]

Elective Treatment means: medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Insured's Effective Date of coverage.

Elective treatment includes, but is not limited to; tubal ligation; vasectomy, breast reduction unless as a result of mastectomy; sexual reassignment surgery; sub mucous resection and /or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; learning disabilities; immunizations; botox injections, treatment of infertility and routine physical examinations.

Eligible Expense as used herein means: a charge for any treatment, service or supply which is performed or given under the direction of a Physician for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Group Policy is in force as to the Insured except with respect to any expenses payable under the Extension of Benefits Provision.

Emergency Service means: Health Care Services necessary to screen and stabilize an Insured in connection with an Emergency Medical Condition.

Experimental/Investigational means: a drug, device or medical care or treatment that meets the following:

a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a familiar function, if Federal or state law requires such review and approval;
d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

Geographic area means: the zip code in which the services, procedure, devise, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, devise, drug or supply.

Hospital means: a facility which meets all of these tests:

a) it provides in-patient services for the care and treatment of injured and sick people; and
b) it provides room and board services and nursing services 24 hours a day; and
c) it has established facilities for diagnosis and major surgery; and
d) it is supervised by a Physician; and
e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
f) it is accredited by the Joint Commission of Accreditation of Healthcare Organizations.

Hospital does **not** include a place run mainly: (a) as a convalescent home; or (b) as a nursing home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders or substance abuse or; (d) as a place for the aged unless written authorization is received.

The term Hospital includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Insured; (b) an ambulatory surgical center or ambulatory medical center (c) a mental health Hospital if supervised and licensed by the Department of Mental Health; and (d) a birthing facility certified and Licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital Confinement/Hospital Confined means: a stay of at least 18 consecutive hours or for which a room and board charge is made.

Immediate Family Member(s) means: a person who is related to the Insured in any of the following ways: Spouse, brother-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Injury means: bodily Injury due to an Accident which:

a) results solely, directly and independently of Disease, bodily infirmity or any other causes: and
b) All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

[**Intensive Care Unit** means: a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.]

Medical Necessity/Medically Necessary means: that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will **not** be considered as Medically Necessary if it:

a) is provided only as a convenience to the Insured or Provider; or
b) is not the appropriate treatment for the Insured's diagnosis or symptoms; or
c) exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
d) is Experimental/Investigated or for research purposes; or
e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual Center for Medicare and Medicaid Services Issues Manual; or
h) can be safely provided to the patient on a more cost-effective basis such as outpatient, by different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental or Nervous Disorder(s) means: any condition or Disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder (other than those conditions deemed serious Mental Illness, as defined in the Group Policy) on the date the medical care or treatment is rendered to an Insured.

One Sickness means: a Sickness and all recurrent and related conditions that are sustained by an Insured.

[**Orthopedic Brace and Appliance** means: a supportive device or appliance used to treat a Sickness or Injury.]

Personal Item means: an item that is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

Physician as used herein means:

a) legally qualified person licensed by the state in which he or she practices; and
b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and
c) certified nurse midwives and licensed midwives while acting within the scope of that certification.

The term Physician does **not** include an Insured's Immediate Family Members.

[**[Plan Year]** means: the consecutive 12-month period starting with the Effective Date shown in the Schedule of Benefits. Subsequent [Plan year] run from the anniversary date of Your Effective Date.]

Pre-existing condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the enrollment date. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

Pregnancy shall not be considered a pre-existing condition hereunder

A newborn child, a child placed for adoption, or a newly adopted child under age 18 who begins dependent coverage hereunder within 30 days of birth, placement for adoption, or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

Reasonable and Customary means: the charge, fee or expense which is the smallest of the:

a) actual charge;
b) charge usually made for a covered service by the Provider who furnishes it;
c) negotiated rate, if any;
d) prevailing change made for a covered service in the geographic area by those of similar professional standing as determined by the 90th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies.

Sickness means: a disease or illness including related conditions and recurrent symptoms of the Sickness that begins after the Effective Date of an Insured's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or related cause are considered one Sickness.

Sound Natural Teeth means: natural teeth, the major portion of the individual tooth that is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

Spouse means: Your legal Spouse [or Domestic Partner if recognized by state law.].

Tandem Transplant means: a procedure that requires the patient to undergo two planned autologous stem cell transplants within 6 months. Stem cells are collected once before initial high intensity chemotherapy or radiation therapy. Half of the stem cells are thereafter used for an initial stem cell transplant and the second half are used after recovery from the first procedure.

[Totally Disabled and Total Disability means: with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, it means that the Dependent cannot perform the normal activities of a person of like age and sex.]

[**Urgent Care Facility** means: a licensed facility that provides a variety of medical, surgical and/or pediatric services on an ambulatory emergency or non-emergency basis where the conditions being treated do not require inpatient confinement. Treatment must be under the supervision of a Physician and the facility must include a resident graduate nurse on staff.]

Waiting Period means: The continuous length of time that You must be Actively at Work before becoming eligible to enroll for coverage.

SECTION 3 – EFFECTIVE DATE OF COVERAGE

ELIGIBILITY AND ENROLLMENT

You: You are eligible for coverage when You satisfy the Waiting Period, complete a valid [application][enrollment form], and pay the initial premium.
Dependent: A Dependent is eligible for coverage on the later of the date You:

a) become eligible for insurance; or
b) acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the later of the Certificate Effective Date if Your Spouse is Your legal Spouse on that date or the date of the marriage to You.

Natural Child: From moment of birth.

Adopted Child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.

Stepchild: On the date the child begins residing in Your home.

Special Enrollees

You shall be a ***special enrollee*** provided:

- You or your dependant lost other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage, reduction in benefits of the other coverage or you voluntarily terminate the coverage); or,

- Employer contributions toward such other coverage were terminated; or,

- You or your dependents were covered under a COBRA continuation provision and the COBRA continuation period has been exhausted.

Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a ***special enrollee***.

An otherwise eligible employee who is not covered by the plan, an otherwise eligible employee and dependent who are not covered by the plan, or a participant's dependent who is not otherwise covered by the plan may apply for coverage under the plan as a result of the acquisition of a new dependent by the employee and shall be a ***special enrollee*** provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent.

A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Coverage for a ***special enrollee***, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall begin as of the first day of the calendar month following a timely enrollment request.

EFFECTIVE DATE

Insured: If You enroll within the Enrollment Period after first becoming eligible to enroll for coverage, Your insurance will take effect on the later of:

a) The date You enroll; or
b) The date You satisfy the Waiting Period, if any,

No coverage will go into effect until You have satisfied the Waiting Period.
Insured Deferred Effective Date: If an eligible person is not Actively at Work on the date his or her insurance under the Group Policy is otherwise to take effect, such insurance will take effect on the day after such person returns to active work.

Dependent, except Dependents Acquired after the Effective Date: The Effective Date of coverage for a Dependent is shown in the Schedule of Benefits. In no event will Dependent coverage become effective prior to the date Your coverage becomes effective.

RENEWABILITY

This Certificate may be renewed for further consecutive periods by payment of the renewal premium, in advance or as stated in the Grace Period Provision, at the renewal premium rates then in force. We will never refuse to renew the Group Policy because of any change in an Insured's health or physical condition. We may, at Our option, decline to renew the Certificate if We decline to renew the Group.

Unless the Certificate is renewed as stated in this Provision, coverage will terminate at the end of the period for which premium has been paid, subject to the Grace Period Provision. Termination of this Certificate does not affect the claims which begin prior to the date of termination. All insurance periods start and end at 12:01 a.m. Standard Time, at Your residence.

We will send written notice of any termination or non-renewal including the reasons for non-renewal or termination of this Certificate by certified mail not less than 60 days prior to the non-renewal or termination, except for non-payment of premium. Coverage stops for non-payment of premium at the end of the period for which premium was paid, subject to the Grace Period.

TERMINATION

An Insured's coverage will terminate at 12:01 a.m. Standard Time at Your home on the earliest of the following:

a) The date the Group Policy terminates or the date a Policyholder or sponsoring entity terminates coverage under the Group Policy;
b) The date coverage is terminated by Us for all certificate holders in Your state;
c) The date We receive Your written request to have Your insurance terminated;
d) The end of the period for which premium is paid, subject to the Grace Period;
e) The date an Insured enters the armed forces of any country. Membership in the reserves or in the National Guard is not deemed entry into the armed forces. Active duty service in the reserves or National Guard for a period of 31 consecutive days or more will be deemed entry into the armed forces.
f) With respect to a Dependent Spouse, the date the Spouse no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.
g) With respect to a Dependent child, the date that child no longer qualifies as a Dependent, unless coverage is continued as stated in the Continuation of Coverage Provision.

At least 60 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

SECTION 4 - LOSS OF COVERAGE

Loss of Coverage for Incapacitated Children

Dependent children, insured herein, who reach the limiting age, while covered hereunder, and are incapable of self-sustaining employment due to mental or physical handicap, may continue to be covered regardless of age. The Dependent child must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once every [Calendar Year].

Coverage for a handicapped Dependent child will end on the earliest of:

a) The date the child marries.
b) The date the child obtains self- sustaining employment.
c) The date the child ceases to be handicapped.
d) The date the child ceases to be chiefly dependent upon You.
e) Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days.
f) The date You refuse to allow Us to examine the child.

The date coverage under this Certificate would otherwise terminate.

Termination and Available Coverage After Termination -- COBRA

When an employer is required to comply with the federal law on continuation of coverage known as "COBRA," all eligible Insureds and dependents covered under this Certificate on the date before a qualifying event who would otherwise have lost coverage herein as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to your coverage while you have coverage under COBRA if the Policy would otherwise allow such a child to be covered by the Certificate. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the Insured, such child shall be considered a qualified beneficiary under the Certificate.

The Employer will notify the policy administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he becomes entitled to benefits under Title XVIII of the Social Security Act within 30 days of the occurrence of any of these events. You or Your covered dependent must notify the policy administrator within 60 days of his divorce or legal separation or when a dependent child is no longer eligible for coverage as defined in the Policy, in order for continuation coverage to be offered to the dependent.

The policy administrator will notify You or Your covered dependent of Your right to elect to continue coverage within 14 days from the date the policy administrator is first notified of any of the events described above. The election period shall begin no later than the date on which coverage terminates under the Policy due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

- The date coverage terminates under the Policy due to any qualifying event listed below, or

- The date the policy administrator sends notification to the Insured or covered dependent of his rights under this provision as described above.

Pursuant to the Trade Act of 1974, workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive Trade Act Assistance ("TAA") and may elect continuation coverage during a 60 day period that begins on the first day of the month in which he or she is

determined to be a TAA eligible person. The person may elect coverage for himself and his family. The election must be made not later than 6 months after the date of TAA related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date which the coverage originally ended.

Benefits will be identical to those available under this Policy to all active Insureds and covered dependents that are similarly situated beneficiaries.

We require You and/or Your covered dependent pay for all or part of the cost for continuing the coverage, not to exceed 102% of the premium. Payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- The death of the participant,
- The divorce or legal separation of the participant from the covered dependent spouse,
- The participant becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or
- With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the Policy.

You and Your covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the Policy:

- Your employment with the employer terminates (except if due to the participant's gross misconduct), or

- You are laid off or Your working hours are reduced so as to render him ineligible for coverage as defined in the Policy.

If the You or Your covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

- The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;

- The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within the later of 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage, and before the end of the original 18-month continuation of coverage period;

- You must notify the policy administrator within 30 days after the final determination is made that the person is no longer totally disabled; and

- The cost for coverage for months one through 18 will be at the rate of 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

- When You or Your dependent fails to make the required contribution (if any) to the plan administrator before the due date or within a grace period of 30 days;

- When the employer or covered dependent first becomes covered by any other group health Policy, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;

- When the Policyholder ceases to maintain any group health Policy; or

- In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled.

A retired Insured and his or her spouse who would otherwise lose health coverage under the Policy after the employer files a Chapter 11 bankruptcy proceeding may continue coverage under the Policy until the death of the insured. Upon the death of the retired covered insured, his covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

If Your or Your dependent first becomes covered under another group health Policy or Medicare while covered hereunder, continuation coverage may continue only during the time that the new group health Policy contains any exclusion or limitation which relates to a pre-existing condition of the insured or dependent. Normal payments for this coverage must be made in order for continuation coverage to remain in effect.

Any other group health Policy will be considered the primary coverage and must always pay benefits before this Policy will consider a claim for benefits. The only exception is that the Policy will remain primary if the COBRA covered person is covered by Medicare by reason of end stage renal disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period, another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

CERTIFICATES OF CREDITABLE COVERAGE

We will issue Certificates of Creditable Coverage for each Insured whose coverage under the Group Policy is terminated. In addition, Certificates shall be issued when requested by an Insured, so long as such request is made within 24 months after cessation of coverage under the Group Policy. Such issuance will occur within a reasonable time.

SECTION 5 – GENERAL PROVISIONS

Grace Period: No Grace Period is allowed for the first premium. A Grace Period of 31 days is allowed for payment of each premium due after the first premium. We will continue Your insurance during the Grace Period. However, if We do not receive Your payment by the end of the Grace Period, Your coverage will terminate retroactive to the premium due date that You failed to pay the required premium. The Grace Period will not continue coverage beyond a date stated in the Termination Provisions.

Notice of Claim: Written notice of claim must be given to Us or Our authorized representative within 90 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Insured.

Claim Forms: We, upon receipt of written notice of claim, will furnish to the Claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the Claimant shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be given to Us or Our authorized representative within 90 days after the covered loss. If proof of loss is not given within 90 days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible. Unless the Insured is legally incapacitated, written proof must be given within 1 year of the time it is otherwise required or the claim will be denied.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless this Certificate provides for periodic payment.

Payment of Claims: Benefits unpaid at the Insured's death may, at Our option, be paid either to such beneficiary or to the Insured's estate. All other benefits will be payable to the Insured.

If any benefit of this Certificate is payable to an Insured's estate, or to someone who is a minor or otherwise not competent to give a valid release, then We may pay up to $1,000 to any relative by blood, or connection by marriage to the Insured or to the beneficiary who is deemed by Us to be equitably entitled to it. Any such payment made in good faith shall fully discharge Us to the extent of such payment.

Unpaid Premium - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Physical Examination: We, at Our own expense, shall have the right and opportunity to examine an Insured as it may reasonably require while a claim is pending.

Legal Actions: A legal action may not be brought to recover on this Certificate within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 Years from the time written proof was required to be given.

[Subrogation: When benefits are paid to or for You or for a Dependent under the terms of the Group Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured or Dependent against any person who might be acknowledge to be liable by a Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by Us of the benefits we have paid for such hospitalization and treatment]

Assignment: You may assign all of Your rights, privileges and benefits under the Group Policy. We are not bound by an assignment until We receive and file a signed copy. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and Federal laws and the terms of the Group Policy.

Medical Claim Payment and Appeals:

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the Insured will be notified of the policy administrator's decision as soon as possible, but no more than 72 hours after the policy administrator receives the claim. If the treating physician classifies a claim as "urgent," the Policy will do so as well.

Extensions:

If information to support a review of an "urgent" claim is incomplete, the following will occur;

- The policy administrator will notify the Insured of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.

- The Insured has 48 hours to provide the missing information or the review of the "urgent" pre-service claim will be closed.

- The policy administrator will make its decision within 48 hours after it receives all necessary information. If a supplemental submission of information is deficient, the time frames begin again.

If an Insured appeals the denial of a pre-service "urgent" claim, the policy administrator must render a review decision as soon as possible, but no more than 72 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Policy:

If a policy administrator has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the policy administrator must notify the Insured of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the Policy has been amended to reduce or end coverage for the treatment, or when the Policy itself terminates.

Extensions of Treatment:

When an Insured requests an extension of an on-going course of treatment beyond that which the policy administrator has approved, the policy administrator must do the following:

- Make a decision about the extension as soon as possible; and

- Notify the Insured of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Managed Care Program

The managed care program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

Pre-Certification Process

Participants or their dependents with the benefit of a managed care program must have every inpatient hospital stay, other than maternity, certified. This is a participant-driven and participant-responsible program. The participant or agent for the participant may call or have the admitting physician or hospital call to certify the stay. Medical, surgical and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within two working days of admission. Maternity admissions for deliveries **do not** require certification. If the newborn baby stays longer in the hospital than the mother, the newborn's continued hospital stay must be certified.

Except in the case of maternity, at the time a medical, surgical or psychiatric inpatient hospital admission is planned, the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre-certification. A penalty per admission as shown in the schedule of benefits will be reflected to the participant if pre-certification requirements are not followed.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

- Plan participant name
- Company name
- Patient's name and age
- Admitting physician's name, address and phone number
- Name of hospital and address

Calls received after hours will be recorded, and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two working days of the emergency admission.

Concurrent Review

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The pre-certification unit staff will monitor the patient's progress throughout the hospital stay to assure discharge is not delayed by inadequate planning and that each day of confinement is medically necessary and appropriate.

The pre-certification staff will contact the hospital utilization review department or the admitting physician for information if additional days are needed beyond those days initially certified. This concurrent review will continue until the patient is discharged.

Inpatient days certified at admissions DO NOT determine the length of inpatient stay. Only the attending physician determines when a patient is to be discharged. The days anticipated at admission may not be needed, or an extension of inpatient days may be required. The physician determines this.

The appeal process is available for a patient's physician when a determination is made that additional days of inpatient care are not medically necessary.

Pre-Service Benefit Claim Review for Coverage

If the policy administrator requires that benefits for a service be predetermined prior to the service being provided, the Insured or the health care provider must submit a request for that pre-service benefit claim review to the policy administrator. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15-day period may be extended for another 15 days if it is necessary because of matters beyond the Policy's control, and if the policy administrator notifies the Insured of those circumstances and the expected date of the decision before the end of the first 15-day period.

- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the Insured 45 days to submit such information.

Normal Post-Service Health Claims

An Insured or health care provider must file a claim with the policy administrator within the time frames set out in the Policy. A claim will be considered to have been filed upon receipt by the policy administrator. The Insured will be notified within 30 days of receipt of a claim by the policy administrator as to the benefits to be paid for that claim.

Extensions:

- The 30-day period may be extended for 15 days if it is necessary due to matters beyond the control of the policy administrator, but the policy administrator will notify the Insured before the end of the 30-day period of those circumstances and the expected date of the decision.

- If more information is necessary to properly process the claim, a notice will be given within the 30-day period that the policy administrator can not meet the 30-day time frame. The notice will describe the missing information and give the Insured at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45-day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the Policy.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the policy administrator, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;

- A reference to any specific Policy provisions on which the determination is based;

- A description of any additional material or information necessary for the Insured to make the claim payable and an explanation of why such material or information is necessary;

- A description of the policy administrator's review procedures and the time limits which are applicable to such procedures, including a statement of the Insured's right to bring a civil action under Section 502(a) of ERISA;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Policy will provide that criterion free of charge upon request; and

- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the policy administrator will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the policy administrator will do the following:

- Allow an Insured 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the policy administrator at the address found in the summary Policy description;

- Allow an Insured the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Provide an Insured, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the Insured's claim for benefits;

- Provide for a review that takes into account all comments, documents, records, and other information submitted by the Insured relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Policy who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual;

- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate policy administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify medical or vocational experts whose advice was obtained on behalf of the Policy in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

- Notify the Insured of the policy administrator's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the Insured's appeal, unless the policy administrator determines that special circumstances require an extension of time for processing the appeal.

SECTION 6 - COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does **not** include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Insured. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the Insured is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured is not an Allowable expense.

The following are examples of expenses that are **not** Allowable expenses:

(1) The difference between the cost of a semiprivate hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If an Insured is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If an Insured is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If an Insured is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that

provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because an Insured has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed panel plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the [calendar year] excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When an Insured is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B.(1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

The Plan of the parent whose birthday falls earlier in the [calendar year] is the Primary plan; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to [calendar year] commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;

The Plan covering the spouse of the Custodial parent;

The Plan covering the non-custodial parent; and then

The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a [Calendar year] are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If an Insured is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The policy administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other Plans covering the person claiming benefits. The policy administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give The policy administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, The policy administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The policy administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by The policy administrator is more than it should have paid under this COB provision or for any amount paid out as a part of normal claim payments, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 7 – COVERAGE DESCRIPTIONS

All benefits under the Group Policy are shown in the Schedule of Benefits. The Schedule of Benefits also shows You the annual Plan Maximums, Lifetime Maximums, deductibles and co-payments per Insured for each benefit provided. The benefits are described and governed by the pages attached to and made a part of the Group Policy. For In-Network Eligible Expenses, benefits are payable at the percentage shown in the Schedule of Benefits for each benefit provided. For Out-of-Network Eligible Expenses, benefits are payable at the percentage shown for the Reasonable and Customary charges incurred.

[**INPATIENT CARE**
[If an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for Surgery, Physicians Services, Hospital Inpatient (including room and board, surgeon services and anesthesia), or Other Hospital Charges, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Benefits for Hospital care include Eligible Expenses incurred for Hospital Room and Board Expense, Intensive Care, and Other Hospital Charges for Miscellaneous Hospital Expense including for anesthesia and operating room; laboratory tests and X-rays; oxygen tent; drugs, medicines, dressings and other Durable Medical Equipment and other Medically Necessary and prescribed Hospital Expenses. If while confined as an inpatient an Insured requires the services of a Physician other than a Physician who perform surgery on, or administered anesthesia to, the Insured, We will pay a benefit for Physician Services.]

[We will also pay benefits for Surgical Expenses. Surgical Expense means charges by a Physician for:

a) a Surgical Procedure;
b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
c) usual postoperative treatment.

Surgical Procedure means:

- a cutting procedure;
- suturing of a wound;
- treatment of a fracture;
- reduction of a dislocation;
- radiotherapy (excluding radioactive isotope therapy)
- cutting operation for removal of a tumor;
- electrocauterization;
- diagnostic and therapeutic endoscopic procedures;
- injection treatment of hemorrhoids and varicose veins;
- an operation by means of laser beam;
- casting;
- removal of a foreign body;
- drainage or aspiration;
- implant;
- catheter placement;
- microsurgery

The maximum benefit payable and co-payment amounts are shown in the Schedule of Benefits.

When an Assistant Surgeon is required to render technical assistance at an operation, the Schedule of Benefits will apply when services are provided by a network provider and if a non-network provider is used, the eligible expense for such services shall be limited to 25% of the reasonable and customary charge for the surgical procedure

If multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s).

Treatment performed outside the Hospital will be paid the same as if performed in a Hospital provided it would have been covered on an inpatient basis.]

[**BENEFITS FOR MATERNITY**

Maternity benefits are available to You and Your Spouse only.

When an Insured is confined to a Hospital as a resident inpatient for childbirth, We will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

a) 48 hours after a non-cesarean delivery; or
b) 96 hours after a cesarean section;

for the mother and the newborn infant(s), unless, at the mother's option, an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. We will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

In the event such earlier discharge occurs, at least one home visit will be available to the mother, and not subject to any deductibles, coinsurance, or co-payment.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) will be conducted within 24 hours following:

a) discharge from the Hospital; or
b) the mother's request; whichever is later.

Benefits include:

a) parent education;
b) assistance and training in breast or bottle feeding; and
c) the performance of any necessary maternal and newborn clinical assessments.]

One ultrasound test will be payable per pregnancy without any additional diagnosis. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary. In addition, for a female Insured over 35 Years of age, charges for the following tests may be considered Eligible Expenses:

- Amniocentesis/AFP Screening;
- Chromosome testing; and
- Fetal stress/non-stress tests.

This Provision is subject to all of the terms of the Group Policy.]

[**OUTPATIENT EXPENSE**
If, by reason of Injury or Sickness, an Insured requires Medically Necessary treatment in a Physician's office, Urgent Care Facility, or licensed ambulatory surgical facility, We will pay the benefits for the treatment and other office services related to such treatment. Treatment of pregnancy is on the same basis as any other Sickness. Benefits include diagnostic X-ray and laboratory examinations, and radiotherapy.

The Covered Percentage, deductible, co-payments and Plan maximums are shown in the Schedule of Benefits.

If the services are in connection with surgery and the Physician is the surgeon who performed the surgery, no benefits are payable under this Provision.

Benefits are payable for Eligible Expenses incurred for the following tests:

- pregnancy tests;
- CBC;
- Hepatitis B Surface Antigen;
- Rubella Screen;
- Syphilis Screen;

- Chlamydia;
- HIV;
- Gonorrhea;
- Toxoplasmosis;
- Blood Typing ABO;
- RH Blood Antibody Screen;
- Urinalysis;
- Urine Bacterial Culture;
- Microbial Nucleic Acid Probe;
- AFP Blood Screening;
- Pap Smear;
- Glucose challenge Test (at 24 weeks gestation); and
- PSA

[**PREVENTIVE CARE**
Benefits are payable for Eligible Expenses incurred by an Insured for the following preventive care. The charges must be incurred while an Insured is insured for these benefits. The annual maximum benefit and co-payment are shown in the Schedule of Benefits. The deductible provision does not apply to these benefits.

Cervical cytology screening and screening mammography

Eligible Expenses include the following:

a) in the case of benefits for cervical cytology screening, annual screening for women (18) eighteen Years of age and older. This coverage shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection, with examining and evaluating the Pap smear.

b) In the case of mammograms:

   1) a baseline mammogram for women at least age 35 but Younger than 40 Years of age.
   2) a mammogram every two Years for asymptomatic women age 40 but Younger than 50 Years of age or more often if recommended by the patient's Physician.
   3) A mammogram every Year for women age 50 or older.

Screening mammography means radiological examination of the breast of asymptomatic women for the early detection of breast cancer, which examination shall include:

a) a cranio-caudal and a medial lateral oblique view of each breast; and
b) a licensed radiologist's interpretation of the results of the procedure. Screening mammography shall not include diagnostic mammography, additional projections required for lesion definition, breast ultrasound, or any breast interventional procedure. Screening mammography shall be performed by a mammogram supplier who meets the standards of the Federal Mammography Quality Standards Act of 1992.

Routine Annual Examination for Adult Insured: Benefits are also payable for one annual check-up to a Physician per Insured for a wellness visit. Benefits include all related charges up to the amount shown in the benefit schedule.

Routine Well Child Care Benefits: Benefits are payable for child wellness services which are rendered during a periodic review are covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one visit. Covered services include: medical history; measurement of height, weight and head circumference; testing of blood pressure; sensory screening including vision and hearing; hereditary and metabolic screening in accordance with state law; developmental/behavioral assessment; immunizations consistent with prevailing

American Academy of Pediatric Committee statements; tuberculin test; hematocrit or hemoglobin; urinalysis; and anticipatory guidance.]

[EMERGENCY ROOM SERVICES
Subject to any co-payment, if an Insured incurs Eligible Expenses in a Hospital Emergency Room for treatment of a medical emergency due to Injury or Sickness, we will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers. The co-payment is waived if the Insured is admitted to the Hospital as an inpatient.]

[SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are payable if an Insured incurs Eligible Expenses for treatment of a medical emergency due to an Accident, we will pay the benefits shown on the Schedule of Benefits on the percentages shown for In-Network or Out-of-Network Providers.]

[CARDIAC, OCCUPATIONAL, PHYSICAL, PULMONARY, SPEECH THERAPIES, AND CHIROPRACTIC CARE
Subject to any co-payment and deductible requirements, if an Insured incurs Eligible Expenses due to treatment of Injury or Sickness for cardiac, occupational, physical, pulmonary, and speech therapies and chiropractic care, we will pay the benefits shown in the Schedule of Benefits. The treatment must be for rehabilitation, must be Medically Necessary, and be prescribed by a Physician.

These services/therapies each has a benefit maximum of 20 visits per Insured, per [plan year] whether provided on an out-patient or inpatient basis. The benefit maximum renews each [plan year].

Each treatment date counts as one visit for each service provided, even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides You with physical therapy and occupational therapy on the same day, the services are counted as one visit for physical therapy and one visit for occupational therapy. An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied toward the maximum benefit limit.

Physical therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a neuromuscular condition that can be significantly improved within a 6-month period of time.

We pay for physical therapy performed by:

- A doctor of medicine, osteopathy or podiatry
- A dentist for the oral-facial complex
- An optometrist for services for which they are licensed
- A certified nurse practitioner
- A licensed physical therapist under the direction of a Physician
- Other individuals under the direct supervision of a licensed physical therapist, MD or DO or
- A licensed independent physical therapist
-

Services do not include:

- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy
- Physical therapy performed by a chiropractor except mechanical traction

Speech and language pathology services must be:

- Prescribed by a Physician licensed to prescribe them
- Given for a condition that can be significantly improved within 6-months
- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist.

The clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

Occupational Therapy must be:

- Prescribed by a Physician licensed to prescribe it and
- Given for a condition that can be significantly improved within 6 months and
- Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of in which he or she practices). The occupational therapy assistant must be under the direct supervision of a registered occupational therapist, who cosigns all assessments and patients' progress notes.

Services do **not** include:

- Occupational therapy examinations or evaluations without an occupational therapy treatment plan and where there is no progress
- Treatment to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- Recreational therapy

Cardiac Rehabilitation Therapy includes intensive monitoring (EKGs) and/or supervision during exercise in a Physician-directed clinic (one in which a Physician is on-site).

Chiropractic services include manipulations of the musculoskeletal system, which includes manipulation of muscles, joints, soft tissue, bone, spine, as well as traction and massage, applications of heat or cold by a Physician or chiropractor.

Pulmonary Therapy includes respiratory therapies prescribed by a Physician as Medically Necessary treating Insureds with chronic breathing problems that include:

- Asthma
- Emphysema
- COPD (Chronic Obstructive Pulmonary Disease)
- Sarcoidosis
- Cystic Fibrosis
- Pulmonary Fibrosis
- Chronic Bronchitis
- Interstitial lung Disease
- Pre and post lung volume reduction surgery
- Bronchiectasis
- Other cardiopulmonary disorders]

[**TRANSPLANT RELATED EXPENSES**
Subject to any deductible payment, if an Insured incurs Transplant related Eligible Expenses, We will pay the benefits shown on the Schedule of Benefits based on the percentages shown for In-Network or Out-of-Network Providers.

Allogenic Transplants
We will pay the Reasonable and Customary expenses incurred for allogenic transplants as follows:

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is: a) A first degree relative and matches at least four of the six important HLA genetic markers with the patient; or b) Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This Provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.) Harvesting and storage will be covered if it is not covered by the donor's insurance. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants
We will pay the Reasonable and Customary expenses incurred for autologous transplants as follows:

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
- Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of "Tandem Transplant" in the Definitions Section.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Aplastic anemia
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency Disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)

- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Megakaryocytic thrombocytopenia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucolipidoses (e.g., Gaucher's Disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's Disease (high risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

NOTE: In addition to the conditions listed above, We will pay for services related to, or for high dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage to antineoplastic drugs when a state law requires that these drugs, and the reasonable cost of their administration, be covered.

We do **not** pay the following for bone marrow transplants:

- Services that are not Medically Necessary
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- An allogeneic tandem transplant
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

Specified human Organ Transplants
When performed in a designated facility, We pay for transplantation of the following human organs:

Combined small intestine-liver
Heart
Heart-lung(s)
Liver
Lobar lung
Lung(s)
Pancreas
Partial liver
Simultaneous pancreas-kidney
Small intestine (small bowel)

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided while coverage is in force under the Group Policy and such services must begin five days before and end one Year after the organ transplant to be covered.

When directly related to the transplant, We pay for:

Facility and professional services
Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed.

Medically Necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during a benefit period and is the direct result of the organ transplant surgery.

We do **not** pay for the following for specified human organ transplants:

- Services that are not covered benefits under the Group Policy
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
- Anti-rejection drugs that do not have a Food and Drug Administration marketing approval
- Transplant surgery and related services that are not performed in a designated facility. You must pay for the transplant surgery and related services You receive in a non-designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and Hospitalization
- Services prior to Your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under the Group Policy
- Experimental transplant procedures. See the definition of experimental treatment

SECTION 8- EXCLUSIONS AND LIMITATIONS

The following are not Eligible Expenses and not covered under the Group Policy:

1. [Injury arising out of or in the course of employment, or activity for wage or profit, or which is compensable under Workers' Compensation or Occupational Disease Act or Law.]
2. [Experimental or investigational services, drugs, or supplies except to the extent required by law;]
3. [Educational testing or training related to learning disabilities or developmental delays;]
4. [Custodial care or personal items;]
5. [Any expense incurred before the Effective Date of an insured's insurance under the Policy or after the termination date of an Insured's insurance.]
6. [Eye surgery to correct refractive errors;]

7. [Therapy, supplies, or counseling for sexual dysfunctions]
8. [Performance, or lifestyle enhancement drugs or supplies]
9. [Artificial insemination, in vitro fertilization, or embryo transfer or any related procedures except where required by law to be covered]
10. [Routine physical, vision, or hearing exams, immunizations, or other preventive services or supplies, except to the extent that coverage is specifically provided under the Group Policy;]
11. [Dental care except for Injury to sound natural teeth;]
12. [Elective surgery;]
13. [Cosmetic Surgery other than reconstructive Surgery incidental to or following surgery resulting from trauma, infection, or other Diseases of the involved part; or reconstructive surgery because of a congenital Disease or anomaly;or according to the requirements of the Women's Health and Cancer Rights Act]
14. [Speech therapy except as otherwise specifically covered under the Group Policy;]
15. [Inpatient or outpatient treatment of alcoholism, drug abuse, and mental illnesses; except where required by law]
16. [Private duty nursing;]
17. [An Injury sustained while the Insured is legally intoxicated or under the influence of alcohol as defined by the jurisdiction where the Accident occurred;]
18. [Charges made to treat a Sickness or Injury sustained while flying as a pilot or crew member;]
19. [Voluntary sterilization procedure or the reversal of a sterilization procedure;]
20. [Weight control services including surgical procedures, medical treatments, weight control/loss programs; food supplements or exercise programs or equipment; and]
21. [Intentionally self inflicted injury or action unless the result of a medical condition]
22. [War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.]
23. [Services and supplies not medically necessary, recommended or approved for the diagnosis, care, or treatment of the disease or injury involved by the treating physician.]
24. [Charges made for: manipulative (adjustive) treatment; or treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.]
25. [Prescription drugs and medicines prescribed by a physician [on an outpatient basis]]
26. [Charges in excess of the Recognized Charge, based on the 90th percentile of the Medicode Medical Data Research Tables.]
27. [Charges for any treatment received while in a skilled nursing facility will not be covered.]
28. [Charges for any treatment for Home Health Care, except as covered under maternity.]
29. [Transportation charges, including ambulatory services.]
30. [Charges for biofeedback.]
31. [Any Treatment received under hospice care.]
32. [Elective or voluntary abortions, except in the case of rape, incest or congenital deformities.]
33. [Charges for Prosthetics and/or orthotics.]
34. [Charges for Temporomandibular Joint Disorder (TMJ).]

PRE-EXISTING CONDITIONS: Expenses incurred for treatment of Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy.

Pre-existing Conditions are not covered for the first 12 months following an Insured's Effective Date of coverage under the Group Policy. This limitation will **not** apply if:

a) The individual seeking coverage under the Group Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage Credit will be given for the time the individual was covered under prior Creditable Coverage that is not separated by a break in coverage of 63 days or more; and
b) The individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

Pre-existing Conditions does **not** apply to:

a) a newborn Dependent child; or
b) a child adopted by the Insured or placed with the Insured for adoption, if adoption or placement for adoption occurs while covered under the Group Policy.

CREDIT FOR PRIOR COVERAGE: An Insured whose coverage under prior Creditable Coverage ended no more than 63 days before the Insured's Effective Date under the Group Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break. The Insured must provide proof of prior Creditable Coverage.

Creditable Coverage means coverage under any of the following:

a) Any individual or Group Policy, contract, or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee Plan, or any other entity, and that arranges or provides medical, Hospital and surgical coverage not designed to supplement other private or governmental plans;
b) The Federal Medicare Program pursuant to Title XVIII of the Social Security Act;
c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
d) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);
e) a medical care program of the Indian Health Service or of a tribal organization;
f) a state health benefits risk pool;
g) a health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) Federal Employees Health Benefits Program (FEHBP);
h) a public health plan as defined under section 5(e) of the Peace Corps Act (22 U.S.C.A. Section 2504(e)); or
i) any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the Federal Public Health Services Act (42 U.S.C. Section 300gg(c)).

Creditable Coverage includes continuation or Conversion coverage but does **not** include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.